What is the experience of the therapist and parent worker dyad in the therapeutic work with racially marginalised families?

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A thesis submitted for the degree of Professional Doctorate
in
Child and Adolescent Psychoanalytic Psychotherapy

Tavistock and Portman NHS Foundation Trust

University of Essex

September 2025

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Abstract

The relationship between children's therapists and parent workers represents an underexplored dynamic within the existing literature. This research explores the experience of this therapeutic dyad, examining the role of transference and countertransference within the relationship, and how these processes shift when working with racially marginalised families where trauma is linked to migration, displacement, and colonialism.

To investigate these questions, the researcher conducted semi-structured interviews with four pairs of child psychotherapists each pair comprising of a child's therapist and a parent worker and analysed the data using Interpretative Phenomenological Analysis. This led to the identification of three key themes. The first, '*Being with trauma: somatic and emotional responses in the dyad,* explores participant's somatic and emotional responses, including racial injury and racial trauma. The second theme, '*Taking up the role: authority, containment and the working relationship,* examines the development of the therapeutic alliance between the patient and therapist, and between parent and parent worker as well as the experience of working as a team, including the challenges of taking up authority within the dyad. The final theme '*In the room: participants' experience of sameness and difference* analyses how participants used the psychotherapy model to help make sense of racial, gender and class similarities and differences.

Keywords: child psychotherapy, parent work, trauma, racially marginalised, race, class, gender, sameness and difference, transference, countertransference, power dynamics.

Introduction

> "*Without an appreciation of all racial experiencing, the issue of race and difference can be kept safely in the realms of academic research and theory, a disembodied concept devoid of all meaning and understanding in therapeutic spaces."*
>
> (Wright, 2021, p.50).

This research project explores the experience of child psychotherapists (CP) working together as therapists and parent workers (PW). This is a relationship that has received little attention in the existing literature. Drawing on an IPA analysis, the study examines the roles of transference and countertransference within this relationship, and how this dynamic may shift when working with racially marginalised families. It considers how intergenerational trauma, particularly in relation to migration, displacement, and colonial histories, shapes and intensifies the therapeutic dyad. Given the complexities inherent in therapeutic work, this study seeks to move beyond theoretical discourse, encouraging child psychotherapists to engage deeply with the impact of trauma and identity - on themselves, on their professional relationships, and on their work with families and the wider support network.

The researcher is a trainee Child and Adolescent Psychotherapist (CAPT) working within a Child and Adolescent Mental Health Service (CAMHS) team that provides consistent and structured parent work, alongside individual child psychotherapy, as part of its therapeutic approach. Despite the stability of this model, the researcher observed significant challenges in maintaining therapeutic engagement with racially marginalised families, particularly when a history of trauma was present. These challenges raised important questions about how trauma, whether personal, familial, or historical, can manifest in therapeutic spaces, influencing both the therapeutic alliance and the wider therapist-parent worker dynamic.

The researcher considered the impact of colonialism on the development of therapeutic frameworks. Many traditional psychotherapeutic models have emerged from Eurocentric perspectives, often overlooking the lived experiences of racially marginalised communities and the ways in which historical and systemic trauma shape their engagement with mental health services. The legacy of colonialism, alongside experiences of migration and displacement, can surface as anxieties, disruptions, or unconscious enactments within the therapeutic dyad. Contributing to ruptures in the relationship and influencing the ability to sustain meaningful therapeutic work.

It is within this context that the therapist-parent worker dynamic becomes particularly significant. How do the histories and lived realities of these families shape the therapist-parent worker relationship? How might the therapists' own backgrounds, biases, and unconscious identifications affect the therapeutic dynamic? These are the questions that guided the researcher in the study, and for which IPA offered an appropriate framework.

The study therefore seeks to foster greater awareness of these complexities through an exploration of the therapist-parent worker dynamic, aspiring to contribute to a more nuanced and reflective practice, one that acknowledges, rather than avoids, the influence of history, culture, and personal experience in shaping therapeutic work with racially marginalised families. Similar to the psychoanalytic task, this research invites the reader into a dialogue, to participate in the thinking and be a part of the journey.

Terminology Considerations

Change of term

Due to the nature of the research, careful consideration was given to the language and terms used to describe the groups and communities whose experiences are the focus of this research. The researcher initially used the term *'non-White'* in the

research question, as reflected in the documentation in the appendices. However, upon completing the analysis and discussion, the researcher recognised that this term inadvertently reinforced the very divisions it aimed to address by defining racial and ethnic groups in opposition to *'White'*, thus contributing to an 'othering' effect.

After careful consideration, the researcher explored alternative terms, including *ethnically marginalised* and *racially marginalised*. The researcher is aware that the term 'marginalised' can be contested by some people, due to it being used as descriptor of character or a process imposed on communities. To ensure clarity and continuity within the study, the term *racially marginalised* has been used to describe communities that have experienced marginalisation based on race or ethnicity, where a more specific descriptor is not applicable. This revision aligns with the study's objective of critically examining experiences related to racial and ethnic disparities whilst using language that better reflects the experiences of affected communities.

Capitalisation of Black and White

The terms "Black" and "White" are capitalised when used to describe racial identity. This decision recognises the fact that these terms are more than just description of colour.

Literature Review

This literature review will outline the historical and theoretical context in which this study is situated. It will begin by examining the development of parent work within child psychotherapy and the broader UK healthcare system. Following this, a review of empirical and clinical studies, alongside both historical and contemporary social and psychoanalytic theories, will explore psychotherapy with racially marginalised families, as well as the lasting impact of trauma and identity. Finally, the review will consider the role of transference and countertransference, examining how these dynamics emerge within the therapeutic work and can influence the therapist-parent worker relationship. Due to an absence of literature or research on this dynamic,

comparisons will be made between the therapist-parent worker relationship and the supervisory relationship. This will explore the impact of countertransference and shed light on the power dynamics present when the parent worker has a dual role as supervisor.

Literature Review Methodology

To conduct the literature review, the researcher accessed different databases such as, but not limited to, APA PsychInfo, PubMed, Medline, PEP Archive, Psychology and Behaviour Sciences Collection and SocIndex via an EBSCOhost account. Papers were searched using the Boolean function 'AND' 'OR'. Keywords searched were **'**parent work', 'child psychotherapy', 'co-therapists' transference', 'intergenerational trauma and colonialism'[1]. Alongside this, journals such as the *Journal of Child Psychotherapy* and the *Journal of Infant, Child, and Adolescent Psychotherapy* were searched, and three unpublished but relevant thesis looking at race within CAMHS have been included. Relevant books were hand sourced from libraries, book shops and the researcher's personal resources. The snowballing technique was also used to pull references from other relevant texts which offered the most success in finding relevant literature.

du Plock (2014) argues that a researcher must take a reflexive stance when doing a literature review, developing a reflective process which records the researcher's responses effectively and critiques how the literature is processed. This is in line with Husserl's (1931) phenomenology, a crucial part of IPA research methodology that will be used. A phenomenological attitude "requires a reflexive move, as we turn our gaze from, for example, objects in the world, and direct it inward, towards our perception of those objects" (Hollway and Jefferson, 2013, p.22).

[1] *see Appendix 1*

Parent Work in Child Psychotherapy

> *The parent worker stands, as it were, on the cusp between our concerns with the inner world of the child and the outer world of family, school, everyday events, and outer reality.*
>
> (Miles, 2011, p.110).

Historical context of parent work

The classical model of child psychotherapy includes parallel parent work alongside individual child psychotherapy. Whilst parent work is an integral part of child psychotherapy training, it is often a relatively small component, and parent workers are typically qualified child psychotherapists. However, this was not always the case; initially, parent work was carried out by psychiatric social workers until the rise of family therapy in the late 1970s. This shift prompted child psychotherapists to develop their own model of parent work, which different to systemic approaches to parent work which examined how parents position responsibility for a child's difficulties within family therapy sessions. Bowen, Madill and Stratton (2002) found that parents can oscillate between "locating problems in others…the illness…or the system" (p.140), attributing difficulties variously to the child, to themselves, or to external systems such as health services. They argue that skilled negotiation of this process between therapist and parent is central to the therapeutic task. These dynamics are not dissimilar to those encountered in child psychotherapy, where Rustin (1998) explores the key questions raised within the child psychotherapy community at that time, particularly how training, with its emphasis on transference and countertransference, could be applied to working with parents.

Despite the integration of parent work into child psychotherapy, Rustin (2009) highlights that "there is a continuing problem in finding colleagues from other disciplines willing to provide any long-term input for parents" (p.206). Currently, the majority of parent work is held by qualified child psychotherapists, whilst trainee child psychotherapists primarily work with children. In some cases, for training purposes, trainees may take on a limited number of parent work cases. Due to this, the number of families in Child and Adolescent Mental Health Services (CAMHS) who can

access child psychotherapy with parallel parent work is limited. In turn this means that the literature focused on child psychotherapy specific parent work is very limited. It is acknowledged that a broader literature review on parent-focused work exists within systemic and family therapy traditions. However, this thesis specifically focuses on parent work as conceptualised within the child psychotherapy profession, given its distinct theoretical basis in transference and countertransference, and unique position of having two therapists working separately with the child and the parent/carers.

Why parent work?

Parent work in child psychotherapy serves multiple purposes and can take various forms, including “separate meetings with parents as an ongoing part of the treatment, direct work with parents instead of work with the child, or inclusion of parents in the therapy sessions themselves” (Slade, 2005, p.2). Cregeen (2016) notes that parent work is sometimes provided briefly to parents of children and adolescents who refuse to engage in therapy or as part of group work interventions (Rustin, 2009; Jarvis, 2005). For this study, the focus is on parent work conducted in parallel to the child’s treatment. It is important to distinguish parent work from adult psychotherapy; its primary aim is to support the child by keeping their needs central (Holmes, 2018).

Rustin (1998, p.235) identifies four main approaches when working with parents:

- gaining the support of parents to protect and sustain the child’s therapy.
- parents seek support for their own parental functioning.
- an agreement to support change in family functioning.
- individual psychotherapy for the parents.

It is recognised that “the parents’ internal world is reflected in the way he or she interacts with his or her child, which in turn influences the development of the child’s internal world” (Altman 2000, p.53). Similarly, Brafman (2001) argues that the interactions between children and parents are so intertwined that it is often difficult to determine cause and effect in their relational dynamics.

The aims of parent work

As previously mentioned, it is important to note that parent work is distinct from individual adult psychotherapy, its primary objective is to support the child by enhancing parental functioning. Novick and Novick's (2005) *Working with parents makes therapy work* is a practical guide with clinical techniques of working with parents. They assert that whilst the therapeutic alliance with parents is not the sole focus of treatment, it plays a crucial role in enlisting parental support for the child's growth and development. It also serves as a valuable lens for understanding the internal parenting functions.

Rustin (2009) describes the significance of helping parents develop awareness of their own unconscious processes:

> "It is all too easy to observe times when parental functioning, which requires adult capacities, is undermined because of overwhelming infantile feelings and phantasies. Finding a way to help parents to become aware of this process in themselves and thus be able to protect themselves is probably our most cherished aim" (Rustin, 2009, p.209).

This process presents considerable challenges, particularly when supporting vulnerable parents. Therapists must balance sensitivity to both the child's needs and the parents' emotional capacity to engage in reflective work. Holmes (2018) suggests that an initial goal of parent work could be to establish an appropriate way of working with the parent(s). Some parents may first need a therapeutic relationship where they feel safe to express confusion, despair, or uncertainty and feel that they can be accepted as they are.

Furthermore, these challenges are compounded by the institutional context in which parent work takes place. Obholzer (1986, p.201) observes that "the term 'institution' can be defined as the coming together of separate parts in the service of a common task", and that that the unconscious institutional dynamics arising from this process, interfere with the functioning of the institution. In CAMHS, where the pressure to

begin a child's therapy quickly following referral is both a clinical and a systemic expectation, the time needed to establish a meaningful therapeutic alliance with parents may itself become subject to institutional pressure. What presents as an operational constraint may therefore also carry an unconscious defensive function, protecting the system from the anxiety of sitting with unmet parental needs before the child's treatment has begun. The researcher suggests that an awareness of these institutional dynamics is an important, if often unacknowledged, dimension of the parent worker's clinical task.

Additionally, Green (2000) emphasises the importance of forming a strong working alliance with parents from the outset. Horne (2020) further argues that establishing a therapeutic alliance with parents needs to be central, first and foremost to working with the child. This initial stage provides an opportunity to explore complex parental emotions, and balance parallel feelings of envy that may disrupt the therapy, such as “the parent's envy of the therapist and the fantasized perfect relationship between "therapist-mother" and… the child's therapy” (Horne, 2000, p.60). However, due to the pressures within the UK CAMHS system to start the child’s therapy quickly after referral, this can result in missed opportunities to observe and explore parental dynamics and engage parents in a meaningful way. Holmes (2018) identifies another essential aim of parent work: “helping parents differentiate their own feelings from those of the child” (p. 265). Similarly, Trowell et al. (2003) stress the importance of enabling parents to see their child as a distinct individual with their own identity.

Additionally, shame is another significant factor in parent work. Frick (2000) suggests that “ambivalent defences against their own traumas… powerful shame or guilt” can make it difficult for some parents to support their child’s therapy (pp.74-75). Rustin (2009) highlights that parents who have a child in therapy may struggle with feelings of failure, fearing judgment and humiliation by professionals. Klauber (1998) explores the impact of parent work on parents of severely disturbed children, warning that “those who undertake work with parents need to be sensitive to their impact on parents who may feel further traumatised rather than supported” (p.85). This can be particularly pronounced for parents with their own history of trauma or mental health difficulties, potentially hindering engagement in parent work. Expanding on this,

Nolte and Wren (2016) conducted a grounded theory study on how parents discuss their mental health challenges with their children. They found that parents' internalised stigma and fears of being seen as “toxic or contaminating” to their children played a significant role in how they engaged in therapy (p.741). Exploring these fears within the therapeutic process can be a crucial part of the parent work, helping parents develop a more reflective and engaged approach to supporting their child’s treatment.

Working with racially marginalised families, including intergenerational and colonial traumas

> *Families today are being harder hit by disintegration, difficult socioeconomic circumstances, migration, alienation, and persecution.*
>
> Tsiantis’ (2000, *(p. xviii).*

Psychoanalysis, difference and the vestiges of colonialism

Tsiantis’ (2000) *Work with Parents: Psychoanalytic Psychotherapy with Children and Adolescents* acknowledges the importance of a psychoanalytic model for children and their families. He asserts that it is the role of the parent worker to acknowledge the trauma caused by external circumstances whilst managing professional network anxieties, protecting the child's therapy, and keeping the child in mind for the parents. Whilst the book is not based on empirical research, it provides a clinical foundation and guidelines for child psychotherapists conducting parallel parent work.

Kareem and Littlewood’s (1992) *Intercultural Therapy* argues that, within the British context, access to health resources has been shaped partly by wealth and education. The book is grounded in theory and clinical vignettes from the therapy conducted at the Nafsiyat Intercultural Therapy Centre in North London. Black and

Asian[2] communities in Britain experience double deprivation due to both working-class poverty and racial discrimination, impacting various aspects of life, including housing, education, job prospects, and health.

Reviewing *Intercultural Therapy* (1992), Davids (1993, p.274) found that it focused on three key issues:

- Psychotherapy is not offered to Black and Asian patients as often as it should be.
- Western-trained therapists have a specific difficulty in acknowledging what it is like to be Black or Asian and hence struggle in addressing this in the transference.
- Because it arose in a particular cultural context, western therapy is not suitable for patients from different cultural backgrounds.

However, Davids (1993), a psychoanalyst who has written about how racist dynamics play out in the unconscious mind, argues that "the aims of intercultural therapy as presented here [by Littlewood] are the aims of any decent therapy; it is not possible to understand a patient's experience without knowing something of the context" (p.274). Littlewood (2000) suggests that therapy should be modified for racially marginalised communities because traditional psychotherapy may not be entirely relevant or applicable to Black and Asian people due to its Western origins. Davids (1993) challenges this point, suggesting that the psychoanalytic technique now “centres on clarifying the patient’s experience in the transference” suggesting that unconscious dynamics are shaped by the external world (p.274). He also cautions that modification can “lead to further marginalisation of an already marginalised group” (Davids, 1993, p.274). However, the findings in Komakech’s (2023, p.119) research on therapist’s experience of working with Black adolescent boys noted that they “reported the need for flexibility within their therapeutic framework, continuous self-reflection, and self-awareness.”

[2] To note, the authors use the political term ‘Black’ to refer to people of African, Caribbean, and Asian heritage, citations from this book are edited to include ‘Black and Asian’. This research uses the term ‘Black’ to include people of African and Caribbean heritage as the experiences of other racially marginalised communities are not directly comparable.

Davids (2011, p.31) further argues that racism is an ordinary defensive mechanism which offers more effective refuge from anxiety than the single defence of projection on its own. With this in mind, we can consider the impact this can have on institutional racism or the therapist's own feelings toward a patient, particularly when they come from different ethnic or socioeconomic backgrounds. Furthermore, Owusu-Bempeh's (2002) chapter on culture and the self, corroborates Littlewood's (1992) assertion that psychotherapy is deeply rooted in Western conceptions of the self. Additionally, Patel et al's (2000) training manual on clinical psychology and race states that "there is generally an assumption that psychotherapy is a body of knowledge which is culture-free, universally applicable and sufficient to address people's problems irrespective of their culture" (p.36). Thinking about how therapists respond to race Horner (2022, p.4) highlighted how "alive race [was] in the minds of the therapists interviewed and yet how often it can be absent or avoided in their work. Clarke's (2003) works on psychoanalysis, and ethnic hatred led him to make the provocative claim that "we are all inherently racist, [or at least prejudiced] and that only sustained and critical self-reflection can move us on from this position" (p.170).

Greene (1985), Littlewood (1988), and Altman (2006) discuss the feelings of superiority or guilt that White therapists and analysts may experience when working with Black patients. Komakech's (2023) research highlighted the need for a more diverse workforce in their research on how Black adolescent boys had responded well to working with Black male staff, as compared to White staff. Considering unconscious colonialist ideology, Fanon (2008, p.9) states that "a man who has a language consequently possesses the world expressed and implied by that language", suggesting that those without access to this language are excluded. Dalal (2002, p.94) expands on this, arguing that embedded in language are definitions of what is considered human (the coloniser) and what is not (the colonised). Lijtmaer (2006, p.130) warns that therapists "need to exercise particular caution against applying [their] metapsychology about minds at large". Arnold (2014) emphasises that cultural norms differ even within individual families and underscores the

importance of "discover[ing] the individual family's cultural pattern of behaviour" (p.129).

Psychoanalytic theory was explored and defined during colonial rule, for instance, Tylor's (1871) *Primitive Cultures*, was widely read by Freud. It laid the foundations for British anthropology, acknowledging that all humans possess the same rational mind, with cultural differences determining the degree to which this rationality is expressed. Tylor (1871, p.26) wrote:

> *"The educated world of Europe and America practically settles a standard by simply placing its own nation at one end of the social scale and the savage tribes on the other, arranging the rest of mankind within these limits accordingly as they correspond to savage or to cultured life".*

Freud (1919) drew heavily on this social anthropological theory in *Totem and Taboo*. Despite being aware of the differences between those who collect the observations and those who examine and discuss them, "[the] colonialist tenets of early anthropological thought continue to circulate throughout psychoanalysis" (Brickman 2018, p.71).

Dalal (2002) examines the history of psychoanalysis and argues that discussions of race have been largely avoided. Pioneering analysts did not directly engage with racism, leading Maharaj (2021) to suggest that "it is tricky to believe that they were not prejudiced by global politics and constructs" (p.119). Freud himself was deeply affected by the rise of anti-Semitism in Europe. Reflecting on his schooling experience, he wrote: "in the higher classes I began to understand for the first time what it meant to belong to an alien race, and anti-Semitic feelings among the other boys warned me that I must take up a definite position…" (Freud, 1900, p.196).

However, Richards (2014) argues that Freud maintained a strong belief that science should transcend racial divisions. Gay (1987) recounts that during this period, “Freud advised Ferenczi, [that] there should not be a particular Aryan or Jewish science. The results must be identical, and only their presentation may vary. If these differences occur in conceptualising objective relations in science, then something is wrong” (pp. 490-491).

Interestingly, in *Narrative of a Child Analysis*, Klein (1961) does not address her Jewish heritage in her work with Richard, despite the fact that their sessions took place during World War II, and Richard frequently expressed fascination with her accent, and preoccupation with German and British military forces. It is possible, as the researcher suggests, that Freud, Klein, and other analysts of the time avoided addressing topics like the impact of immigration on the analytic encounter because the trauma they experienced had not yet been fully mentalised. As Akhtar (2016) explains, “[they] were refugees and they had been traumatized very badly… they did not want to call attention to the fact that they were Jewish… their personal trauma was too painful. And there was no chance of going back. So, they had to adapt” (p.17).

In exploring the impact of racism, Handford and Marrero (2022) define “negative racial experiences” as “the real or perceived interpersonal slights, discrimination, humiliating or shaming events, and threats of harm or injury focused on one’s ethno-racial identity” (p.5). Dalal (2002) critiques psychoanalysis for often neglecting the complex social interactions and power dynamics that underpin such experiences, arguing that this oversight is a fundamental flaw. Salberg and Grand (2017) ask, “if transgenerational transmission enters the core of psychoanalysis, would it transform much of our thinking?” (p.3). This raises a critical question: how can psychoanalysis effectively understand group phenomena, like racism, if it remains primarily focused on the individual?

Arnold (2014) suggests that individuals, “whether of the indigenous population or migrants, asylum seekers or refugees, who have been traumatised, are assessed by therapists, they may be labelled as uncooperative” (p.119). This perception can be rooted in fear; of treatment, of mental health as a concept, or of the healthcare system, particularly if they have been subject to hostile immigration policies. Here, Fanon’s (1952/2008) earlier discussions on language become relevant; how do racially marginalised families who do not possess the language of therapy successfully access it?

Owusu-Bempeh (2002) highlights the distinction between individualist and collectivist cultures, suggesting that psychotherapy could benefit from expanding its understanding of how different cultures perceive the self. Kareem (1992) emphasises the necessity of allowing patients to articulate their own experiences, in order to understand how they perceive their illness or problem. Involving patients in defining their own difficulties from the outset may foster a more inclusive and effective therapeutic approach.

Legacies of trauma

This study recognises the legacy of slavery within families who have not had direct experiences of colonisation or enslavement. Brickman (2018) argues that elements of psychoanalysis, such as transference and the psychology of primitivity, have influenced the clinical relationship in ways that position “the doctor [in] the role of coloniser and the patients as the colonised people” (Mannoni, 1972, p.93). Brickman (2018, p.213) further notes that Freud frequently described transference using metaphors of “combat and legal authority”, portraying treatment as a struggle and stating that “every conflict has to be fought out in the sphere of the transference”. Fletchman Smith (2011, p.107) interestingly states that there may be “ongoing issues around authority, who carries it and who can exercise it safely” which is explored further in this study. Jackson (2022, p.82) also argues that “it would be helpful for professionals to consider where they find themselves on the ‘scale’ of

projections and defences as [they] work to support families". It is worth questioning how families and communities perceive healthcare professionals as 'experts' who wield authority in therapy. The focus here is on the perception of authority rather than on therapists actively adopting an authoritarian stance.

Whilst examining the legacies of slavery, particularly within Caribbean families, Fletchman Smith (2011) suggests that the "installation of fear into the minds of [enslaved people] created an intrapsychic situation in which ordinary castration fears are felt more acutely" (p.106). Additionally, Black British Caribbean communities, many of whom are descendants of the Windrush generation, face the compounded effects of post-colonial displacement and systemic racism, leading to complex intrapsychic conflicts. This raises important questions about the impact of colonialism on therapeutic frameworks, particularly regarding other racially marginalised communities who have experienced similar intrapsychic conflicts due to colonial legacies. The South Asian diaspora, for instance, carries the intergenerational impacts of British colonial rule in Indian and Pakistan. This often manifests as identity conflicts and internalised racism, as explored by Bhugra and Becker (2005) in their work on cultural identity and migration. Akhtar (1995) also highlights how the trauma of migration and cultural dislocation can result in fragmented self-identity and feelings of inferiority, which mirrors Fanon's critique of the Eurocentrism of psychoanalysis, arguing that one of the psychological consequences of colonisation is an inferiority complex.

In a single case study, Arnold (2014) describes her work with an African-Caribbean mother who, as a child, was left in the care of her grandmother in another country. The mother experienced depression and was resistant to psychiatric treatment, whilst her teenage son struggled with anger and resentment, requiring therapeutic support. Although this is just one case, similar referrals are frequently encountered in inner London CAMHS, often involving emotional dysregulation, conduct issues, or mood disorders. Altman (2000) suggests that aspects of a parent's internal world may be transmitted intergenerationally. Barth (1998) expands on this, applying Klein's (1946) concept of projective identification to explain the transgenerational

transmission of psychopathology, wherein unwanted aspects of the self are projected onto another. They acknowledge that when a mother projects her past in the form of her psychopathology onto her child, her capacity to “give back to the baby, ‘the baby's own self’ is restricted” (Barth, 1998, p.31; Winnicott, 1967).

Barth (1998) stresses the importance of not blaming the parents for this transmission as it is likely they are managing their own traumas. Rustin (2000) further suggests that “when we work with parents who are themselves very deprived or have other borderline features, keeping the temperature of the involvement cool may sometimes be wise” (p.3). In Arnold’s (2014) case, her awareness of the mother’s background and an understanding of the effects of broken attachments, separation, and loss were instrumental in shaping the therapeutic work. This acknowledgement meant that the mother was able to disclose ‘long repressed feelings’ and accept the recommendation that her son needed to be seen by a child psychotherapist to explore his painful feelings related to loss and anger (Arnold, 2014, p.125).

This approach is even more crucial for parents with histories of trauma and migration. Gentile (2017) notes that “trauma can obliterate linear narrative, chronological time, and capacities for reflection” (p.171). Therapists must remain mindful of this, as it can affect a client’s ability to recall or reflect on their sessions. Fjeldheim et al. (2024) conducted a qualitative study on the impact of intergenerational trauma on therapists in perinatal psychotherapy. The study posed the critical question, how to help parents become the parents they wished they had without knowing what it looked or felt like (Fjeldheim et al., 2024, p.212).

Although Fjeldheim’s study was relatively small, conducted in Norway, and not focused on parallel parent work, it highlighted areas of relevance to this study, such as the challenge of breaking cycles of violence, abuse, and trauma across generations. The therapists involved adopted Fraiberg et al.'s (1975) ‘kitchen-table psychotherapy,’ which emphasised working flexibly with families entrenched in trauma cycles. However, as with CAMHS in the UK, this approach often conflicted

with service demands and systemic pressures. The study concluded that both therapists and caregivers need to feel safe and secure in the therapeutic space to effectively address generational trauma. It also suggested that “due to intergenerational adversities affecting the lives of families on many levels, flexible use of a wide range of services…is required to fight generations of adversities” (Fjeldheim et al., 2024, p.213).

Identity

Avigad and Pooley’s (2002) *Strangers in Foreign Lands* explores how rapid and violent changes for refugees can "result in the creation of many identities” (p.83). Through a single case study, they describe the importance of broadening the scope of therapeutic support to look beyond ‘pre-trauma and post-trauma’. When working with racially marginalised families with histories of migration or displacement, therapists must consider shifting identities. These may include "the identity present before the trauma; that which is co-constructed at the point of sensing danger; of disaster; of rescue; of asylum seeking; of aloneness; of dislocation; of after" (Avigad and Pooley, 2002, p.84). Lijtmaer (2006) discusses the experience of lacking cultural stability and the negative effects this can have, including disrupted identity formation, splitting, and a diminished sense of self.

Maharaj (2021) poignantly states, "the global borders of colonialism symbolise the markings of historical pain and oppression” (p.119). Colonisation imposed new identities that often-undermined self-esteem and hindered community development. Fanon (1952) explains how Black individuals may experience fragmented identities as a result of assimilation into dominant cultures. Maharaj (2021) writing about the effects of indenture and colonialism on India corroborates this, stating that it imposed new identities on communities which lead to "debilitated self-esteem, self-agency, community and national development" (p.119). Fanon’s work further supports this theory, particularly with regard to Black people, who may experience fragmented identities after losing their native land, culture, and customs through assimilation into an adopted country. Fanon’s ideas can be extended to many individuals with a history of migration and displacement. Arnold (2014) underscores the importance of

acknowledging grief and mourning the loss of cultural connections, as these disruptions impact identity formation across generations.

Transference and countertransference: unconscious communications in relationships.

> *Transference includes everything that the patient brings into the relationship.*
>
> (Joseph 1985, p.447).

The importance of transference and countertransference

As the above quote suggests, transference is an amalgamation of past and present - what Klein (1952, p.437) referred to as "the total situation", in *The Origins of Transference*. This study seeks to explore how the past, not only in terms of childhood or traumatic experiences but also in relation to experiences transmitted intergenerationally potentially manifests in the present relationship between therapist and parent worker. As Joseph (1985) states "everything of importance in the patient's psychic organization… will be lived out in some way in the transference" (p.452).

Reisenberg-Malcom (1999) emphasises the importance of "making sense of the patient's communications and using them to understand the patient's history as it is being re-experienced within the transference" (p.14). An interpretation can either loosen or tighten a person's defence structure, which is particularly relevant when working with patients who have experienced trauma. Joseph (1985) notes that "no interpretation can be seen as a pure interpretation" due to the fluidity and shifts within the transference, this allows the therapist to make interpretations that resonate with the patient's level of functioning (p.447).

Pick (1985) suggests that "the patient desires to eliminate discomfort as well as to communicate and share experience" (p.159). This will then be picked up by the analyst, who may feel an impulse to enact, ranging from implicit indulgence to hostility and distance. Pick (1985) further describes how either response "aims at a

move from the paranoid-schizoid to the depressive position" (p.160). Riesenberg-Malcolm (1999) expands on this, stating that one must focus on the dynamics between the patient and therapist, where "[the analyst] scrutinises his own responses to the patient, trying to understand the effect the patient's behaviour has on himself" (p.39). Joseph (1985) notes that countertransference, once viewed as an obstacle, is now regarded as an "essential tool in the analytic process" (p.447).

These individual and dyadic processes are further complicated when considered within a network or institutional frame. Obholzer and Roberts (2019) draw on Bion's (1967) concept of containment to argue that within any institution, the capacity of staff to think about and metabolise the emotional impact of their work depends on the availability of containing structures, both relational and organisational. Where such structures are absent or under strain, unprocessed material is more likely to be acted out or projected rather than reflected upon, whether within the individual therapist, the dyad, family or wider professional network. For the therapist- parent worker working together, this can suggest that the quality of their relationship, and their shared capacity to think about their respective countertransference responses functions as a micro form of institutional containment.

Halton (cited in Obholzer and Roberts, 2019) further argues that the countertransference responses of staff working with distressed families are not solely an individual phenomenon but are also shaped by the projective processes of the institution as a whole. This has direct relevance for the dyad at the centre of this study, where the unconscious communications between the child psychotherapist and the parent worker may carry material that originates not only in the therapy room or between the therapists, but also in the wider institutional and network context.

The common theme in psychoanalytic papers on race or working with difference (Greene, 1985; Altman, 2006) is the emphasis on the importance of awareness regarding transference and countertransference between the patient and therapist. Altman (2006) helpfully suggests that it is crucial for the therapist to become familiar with their own racial attitudes and feelings, including any racism, in the

countertransference. Lijtmaer (2006) advocates for a relational approach, particularly when working with multiethnic communities, as it allows for consideration of the cultural backgrounds of each individual within the therapeutic relationship. Lijtmaer (2006, p.132) also draws on Foster's (1998) term 'cultural countertransference', which refers to "the therapist's emotional responses to the patient's interactions, based on the patient's race, ethnicity, and religion". Interestingly, the unconscious communication between therapists within the network has not received the same level of attention.

Transference in parent work

Joseph (1985) suggests that the stories a child brings to therapy can be understood as the "unconscious internalised family relationships colouring aspects of the child's stories or play that are connected to the child's relationship to the therapist" (Magagna, 2022, p.322). This insight is valuable for therapists working with families, and can help inform the parent work, which is not typically conducted within the transference.

Edwards and Maltby (1998) consider the role of transference in working with parents and families. Whilst they acknowledge its significance, they do not apply it as directly as they would in individual therapy. Green (2000), however, argues that therapeutic sensitivity is crucial in the use of transference, emphasising that therapists should be guided by the evolving phases of parent work. Sutton and Hughes (2005) expand on this by identifying two levels at which transference can be engaged in parent work:

- "The therapist's use of non-verbalised transference/ countertransference understanding to inform and shape responses.
- The therapist's explicit and verbalised use of transference/ countertransference understanding" (p.175).

Interestingly, Sutton and Hughes (2005) also suggest that whilst transference does not always need to be verbalised, addressing it can sometimes be beneficial, particularly during initial interactions. For example, in the 'very first contact', a

parent's feelings of shame and fear of authority may be defended against through aggression or hostility (Sutton and Hughes, 2005). They strongly argue that the therapist must negotiate a contract to work at both conscious and unconscious levels, "seeking consent to work in different areas" (Sutton and Hughes, 2005, p.175). Horne (2000) however, suggests that much of parent work "takes place at the conscious or preconscious level, working with the functioning ego rather than the unconscious" (p.63). This raises the question of whether the parent worker should engage with transference when necessary to support the overall psychotherapy process.

The parent worker and child psychotherapist relationship versus the supervisory relationship - comparisons

Due to the absence of literature on the unconscious dynamics of the relationship between CP and PW, the researcher has included comparable and potentially relevant literature on the supervisory relationship. This study considers the close relationship between the child psychotherapist and parent worker, which can include elements of supervisory relationship and power dynamics if the parent worker is a qualified child psychotherapist.

Supervision is an "essential prerequisite for the practice of psychotherapy" (Roth and Fonagy, 1996, p.73) and aims to develop a supervisee's competence. Ogden (2005) describes the role of the supervisor in analytic supervision, a perspective equally relevant to child psychotherapy trainees. He states that "the supervisor is responsible for creating a frame that ensures the supervisee's freedom to think and dream and be alive to what is occurring both in the analytic process and in the supervisory process" (Ogden, 2005**,** p.1269). This view highlights how the supervisory relationship is shaped by both conscious and unconscious interactions between the supervisor and supervisee, as well as their shared engagement with the case.

Searles (1995) encouraged supervisors to become more attuned to their emotional responses in supervision. He argued that a supervisor's subjective and personal feelings about the supervisee "often provide valuable clarification of processes currently characterising the relationship between the supervisee and the patient" (Searles, 1955, p.190). Magagna (2022) supports this perspective, noting that "the supervisory process involves the supervisor and trainee therapist's unconscious and conscious interactions [which] both affect the child–therapist relationship and are affected by it" (p.315). For the purposes of this study, this framework could also be applied to the interactions between the therapist and the parent worker. Wilson et al. (2016) conducted a meta-analysis on trainee therapists' experiences of supervision. The study found that trainees valued supervisors who acknowledged differences between them, offered suggestions without imposing immediate action, and were open to discussing "participants' own feelings such as frustration or incompetence" (Wilson et al., 2016, p. 345). Furthering this, Komakech's (2023, p.124) findings suggest that some supervisors may not consciously think about difference and sameness, making it harder for clinicians to bring their thoughts and ideas concerning their work".

Brodsky (2017) examines the triadic nature of supervision, clarifying that supervision in a training context is structured around "multiple triangles that include the trainee, supervisor and academic institution… in this triangle one of the parties often withholds information, or two parties share information to which the third party is not privy" (p.393). Whilst Brodsky (2017) refers specifically to students and supervisors within an institutional setting, this analogy can also be expanded to include the child psychotherapist, patient, parent worker, and parent, with the third-party position shifting depending on context. Magagna (2022) builds on this, stating that "one of the tasks of training supervision is to discover ways of recognising and repairing ruptures in the triangular relationship existing between the child, the therapist, and the supervisor" (p.317).

At times, however, the supervisor may also serve as the parent worker, introducing additional complexities regarding boundaries within the dyad or triad. Since

supervision exists within an academic framework, both the supervisor and supervisee remain subject to the authority of a third-party institution that has “the power to determine [each of their] fate” (Brodsky, 2017, p.395). Magagna (2022) refers to the importance of the supervisor holding a ‘cradle of concern’ for the child’s emotional life and the trainee’s development” (p. 315). This concept can be extended to include the development of the parent worker and the emotional life of the parent. If the parent worker also serves as the supervisor, they must navigate the added challenge of holding this ‘cradle.’

Whilst the parent worker - therapist relationship differs somewhat, since not all parent workers serve as supervisors, these findings offer insights into how therapists can collaborate in thinking about their respective patients. Worthen and McNeill (1996) assert that “the most pivotal and crucial component of good supervision experiences… was the quality of the supervisory relationship” (p.29). Similarly, the quality of the parent worker and child psychotherapist relationship is essential for sustaining therapy. Both therapists must be open to discussing countertransference, particularly since they are both directly involved in the case. This openness may include a willingness to explore differences, acknowledge both positive and negative emotions, avoid becoming “preoccupied with their own ideas” of therapy (Reichelt and Skjerve, 2001, p.32), and engage fully in clinical and peer supervision meetings.

The institutional context

The relationship between the child psychotherapist and parent worker does not exist in isolation but is shaped by the institutional context to which both practitioners belong. Obholzer (1986, p.201) argues that “institutions defend themselves against the anxiety and pain inherent in the workings of the system” and structure themselves in ways that defend against the task. Crucially, this defensive organisation is rarely recognised as such; instead, it is presented as the optimal way of performing the task. This is particularly pertinent to CAMHS, where systemic pressures, including high thresholds, limited resources, and time constraints, may function not only as practical realities but as institutionalised defences against the emotional demands of the work. Obholzer (1986) further notes that the unconscious processes operating across an institution are the same in kind as those operating

within the individual mind, differing only in the boundary one draws around the field of observation. From this perspective, the dynamics between the child psychotherapist and the parent worker cannot be understood solely in terms of their individual counter-transferences; they must also be understood as shaped by, and at times expressive of, the wider institutional processes in which both are situated.

Halton (cited in Obholzer and Roberts 2019) extends this thinking, drawing on Klein's (1946) concept of projective identification to argue that within institutions working with distressed client groups, different staff members may unconsciously come to hold different, and conflicting, aspects of the client group's emotional experience. Regarding the focus of this research, the child psychotherapist and the parent worker may similarly find themselves positioned as recipients of split-off projections from the 'family system', each holding distinct emotional material that, when examined together, reflects the complexity of the family's inner world. An additional dynamic to consider is the triadic structure that Brodsky (2017) suggests, when thinking about what passes between the child psychotherapist and parent worker in their clinical discussions may carry unconscious communications not only from their respective patients but from the institution itself.

Lowe's (2014) *Thinking Space* furthers the discussion on institutional containment, to consider the impact of identity. Specifically, where race is concerned, what is being defended against is not only emotional intensity in general, but a specific and often disavowed dimension of institutional power. Brooks' (2014, p.53) chapter argues that institutions, including psychoanalytically informed ones, can be remarkably swift to dismiss race as a relevant factor in a clinical or organisational difficulty, even while continuing to behave as though "doing a lot of work" on the matter. The act of talking and thinking, can itself function as a defence, allowing the institution to feel it has thought about race without the more painful work of actually doing so. When this defence is present, the containing function that Obholzer and Roberts (2019) describe is compromised specifically along racial lines, as material connected to a family's or therapist's experience of institutional power, marginalisation, or racism may be unable to find a thinking space anywhere in the network, and so is more

likely to be evacuated into action, or to settle, via projective processes, onto whichever colleague is unconsciously available to carry it.

This concern is also echoed in systemic practice literature; Messent and Fredman (Roberts et al., 2014) describe the development of the Social GRRRAAACCEEESSS model within UK systemic therapy, a framework designed specifically to ensure that power and difference, including race, are actively held in mind by clinicians rather than being defended against. Reflecting on his own practice, Messent (in Roberts et al., 2014) acknowledges that his position as a White European clinician means that his encounters with families are shaped by the history of colonial and post-colonial relations between his own and the families' communities. An important reflexive acknowledgement that resonates with this study's attention to the racialised positioning of the family the therapeutic dyad is working with. This suggests that, across both psychoanalytic and systemic traditions, sustaining an active, ongoing attentiveness to race and power, rather than a single act of acknowledgement, is understood as central to working across difference.

Returning to the psychoanalytic literature Bradley's (2014) chapter on being Black in the transference suggests that this availability is not random, his clinical material indicates that one's race, or perceived racial position, can make them a more or less likely recipient of a family's projected material relating to neglect, power, or care experienced as exploitative, regardless of the practitioner's actual relationship to that material. Applied to the dyad at the centre of this study, this raises the possibility that where a family has experienced institutional power as racialised, whether through prior contact with statutory services, immigration systems, or other agencies, this experience may enter the network unconsciously and be differentially distributed between the therapist or parent worker according to each therapist's own racial and cultural position, rather than according to role alone.

This is further supported by Jackson's (2022) research into the underrepresentation of Black children and families accessing CAMHS. The professional focus group identified disjointed thinking within the professional network as a recurring theme directly affecting families' access to and engagement with services, alongside mistrust and fear. Drawing on Klein's (1946) concept of splitting and Mosse's (2019) account of institutional defences, Jackson (2022) argues that organisations, like individuals, develop defences against emotions too threatening to acknowledge, leaving staff at risk of becoming caught up in a system's defensive culture and losing the capacity to think or question. Where institutions lack a space for thinking about race, the splitting and projection that structure relationships between clinicians may come to rest disproportionately on therapists' racialised and cultural identities, with consequences for how the family's material, the dyadic relationship and the institution's own anxieties, are distributed, carried, and potentially left unprocessed.

Taken together, this literature indicates that institutional defences, projective processes and racialised dynamics, shape the network surrounding child psychotherapy work, and that these processes are likely to bear on the CP and PW relationship. However, existing research has largely addressed these dynamics separately, either focusing on institutional defences and containment more broadly, or on race and institutional power in relation to families' access to and experience of services, without examining how they converge specifically within the therapist and parent worker dyad. Jackson's (2022) research comes closest to this focus, but centres on the professional network's disjointed thinking rather than on the dyadic relationship itself, which remains the focus of the present study.

Methodology

This chapter describes the methodological approach taken in this study, beginning with the recruitment process and participant selection, before moving onto the theoretical and analytical framework of Interpretative Phenomenological Analysis.

Recruitment

To start the recruitment process, a discipline-wide email with participant information was initially sent by the course administrator to all trainee Child and Adolescent Psychotherapists (CAPTS) and the team leads of the CAMHS clinics within the Trust. This garnered interest from the trainee child psychotherapists working within the CAMHS clinic and the researcher held informal discussions with them using the inclusion criteria (see below) to assess if the cases were appropriate. The process of recruiting qualified child psychotherapists took longer than anticipated as the emails resulted in no responses. Following discussions with the research supervisor, the researcher approached newly qualified child psychotherapists based in the Trust who had relevant cases with more senior child psychotherapists. Whilst this still did not yield many responses, this approach seemed more fruitful and the researcher wondered if the lack of initial response was due to a capacity issue for qualified child psychotherapists, or an anxiety about the research topic.

Participants were selected using purposive sampling, due to the nature of the study, and the small sample size and to ensure there was a range of therapist identities and eligible cases. All of the participants were either training or qualified child and adolescent psychotherapists, working in teams within the researcher's Trust. The Trust has a long-standing relationship to psychotherapy; thus, parent work is offered alongside individual therapy as the standard treatment. However, due to capacity, trainee child psychotherapists offer the individual therapy, whilst qualified therapists hold the majority of the parent work cases. This is due to the ratio of trainees being greater to qualified staff per team and the frequency of parent work ranging from weekly to monthly meetings. The geographical area of London included was broad, but largely covered North, and North-West London. A total of eight participants from different teams were recruited for this study, making up four pairs, consisting of two

trainee pairs, one trainee and qualified pair and one qualified pair. The resulting sample was intentionally heterogeneous in terms of training status, reflecting the actual structure of child psychotherapy practice within CAMHS. In this context, as mentioned in the literature review, trainee child psychotherapists typically hold individual therapy cases whilst qualified therapists hold the majority of parent work – meaning a supervene/supervisor pairing is not an anomaly but rather an accurate representation of how these dyads operate in practice. Recruiting only homogeneous pairs would therefore have produced a sample that misrepresented the clinical reality,

The composition of the child/parent/therapist/parent worker quartet is illustrated in the following format:

Child	**Parent/Carer**
Child Psychotherapist	**Parent Worker**

Pair One: four months of weekly child psychotherapy and parent work ongoing

Mixed Black boy	White mother
White woman	Black woman

Pair Two: six months of weekly child psychotherapy and weekly parent work for two years ongoing

Black boy	Black grandmother
White woman	Black woman

Pair Three: two years of weekly child psychotherapy and fortnightly parent work, recently ended

Black boy	Black mother
White man	Asian woman

Pair Four: three years of intensive child psychotherapy and parent work, ended two years ago

Black boy	Black father
White woman	White man

Inclusion Criteria

Child and adolescent psychotherapists working in a CAMHS team within the Trust and registered with the Association of Child Psychotherapists (ACP) were all eligible for the research study. A range of identities where possible was aimed for including gender, class, sexuality and race. However, due to the nature of diversity in the profession, the researcher was aware this may not have been possible. Due to the nature of the pair interviews, it was important to recruit child psychotherapist pairs who were offering individual psychotherapy and parallel parent work. The eligibility criteria of the cases included 'non-White'[3] families receiving child psychotherapy and parallel parent work as a treatment.

[3] see Introduction: 'NB change of identity term'.

Data Collection – the interviews:

The researcher conducted in-depth, semi-structured interviews between February 2024 and June 2024 with four pairs of child and adolescent psychotherapists. The interviews took place at the researcher's place of work, on the Trust's main site. Quiet, neutral, and confidential rooms were booked to ensure a comfortable and distraction-free environment. Each interview lasted between 60 and 90 minutes and was scheduled during or after the working day, depending on mutual availability between the participants and the researcher. The interview questions were developed following guidance from Interpretative Phenomenological Analysis (IPA) literature (Smith et al., 2009) and further refined during research supervision sessions. This process ensured that the questions were open-ended and exploratory, encouraging rich, reflective responses.

Semi-structured interviews were chosen for their flexibility and their ability to foster in-depth exploration. They allow participants to "tell their stories, to speak freely and reflectively and to develop their ideas and express their concerns at some length" (Smith et al., 2009, p.56). This approach was particularly suitable for pair interviews, as it enabled participants to interact not only with the researcher but also with each other, fostering dialogue and shared reflection. The researcher drew on child psychotherapy training around reflective practice; being thoughtful, contemplative and working collaboratively in partnership (Connor, 2020).

The interviews aimed to elicit reflections on the families' experiences of the treatment and service, with the hope that deeper insights would emerge through the dynamic interplay between participants. The interview process was also informed by Hollway and Jefferson's (2013) psychosocial approach, which highlights the importance of considering the researcher's influence on participants, the interviewees' motivations and memory, and whether all relevant material has been adequately explored.

The complexities of conducting pair interviews became apparent during the study. Whilst pair interviews offered the advantage of participants building on each other's reflections, they also introduced dynamics similar to those found in group interviews.

For example, interpersonal relationships, power dynamics, and differing communication styles could influence how openly participants shared their thoughts (Kitzinger, 1995; Morgan, 1997). At times, one participant might dominate the conversation, whilst the other became more reserved, requiring the researcher to manage the interaction sensitively to ensure balanced participation. In this study, the pair interviews sometimes mirrored these dynamics, highlighting the importance of the researcher's role in facilitating balanced dialogue and attending to the subtle interpersonal processes that unfolded. It is important to note that these dynamics might have also reflected the case dynamics and potentially shaped participants' reflections on these dynamics which will be explored in later sections.

The questions were deliberately phrased in an open and non-directive manner, inviting participants to bring their own material and language, including in relation to difference and race. The researcher wanted to encourage potentially defended subjects to talk as openly as possible and reflect on the impact of their work on themselves, whilst also getting a sense of their dynamic.

The questions are as follows:

1. Can you describe the case you are working on together, including ethnicity information of the young person and parents/carers. If this is absent, has it been followed up?

2. How long have you been working together for?

3. What was the thinking behind setting the treatment up in this way (individual work plus parent work), including who is offering the parent work and how often.

4. How is the treatment going? (attendance, engagement, for example)

5. Can you describe the network involvement and dynamics as you see it?
6. Has difference come up in the work at all, especially (but not only) around race/ethnicity. Has this been discussed between you or in supervision?

7. Have there been differences of opinion between you regarding the case so far? If so, what and how are these thought about? If not, any reflections on this?

8. Has there been any joint review yet? Was the young person present?

9. Have there been instances where you have had a response about the case that could be linked to unconscious dynamics? Such as a body response (tense, fidgety, distracted) or a feeling towards the child/ parent, therapist / parent worker.

10. Do you think the family's trauma shows up in your work?

Interpretive Phenomenological Analysis

Smith et al. (2009) describe IPA as "an approach to qualitative, experiential and psychological research which has been informed by concepts and debates from three key areas of philosophy of knowledge: phenomenology, hermeneutics and idiography" (p.11). Phenomenology is the study of experience, hermeneutics is the theory of interpretation, and idiography is concerned with the particular. IPA does not set out to prove a hypothesis but rather is focused on "exploring experience and a persons' relatedness to, or involvement in, a particular event or process (phenomenon)" (Smith et al. 2009, p.40).

IPA was selected for this study because the research question seeks to understand the lived experience of the therapist and parent worker dyad, more specifically how participants made sense of their work with racially marginalised families and what this meant for them personally and professionally. IPA's commitment to understanding experience from the participant's perspective, as interpreted through the researcher's own lens, make it particularly well suited to exploring the complex dynamics at the heart of this study.

The in-depth analysis of how the participants relate to each other and the question, as well as the unconscious communication involved in working with racially marginalised families and each other means that IPA is the most natural-fitting methodology to be used.

The Health Education England, Children and Young People's Mental Health Workforce Census for 2021/2022 reported that 80% of the CYPMH workforce is White or White/British (NHS, 2023). The nature of the research question might therefore have beenanxiety provoking for some of the participants, when thinking about their experiences of working with racially marginalised families in a majority White profession and service. Hollway and Jefferson (2013) refer to this as working with "defended subjects [who] may not hear the question through the same meaning frame as the interviewer, and/or may be invested in particular positions in discourses to protect vulnerable aspects of the self" (p.24). The researcher was also aware of possible transferential communications in relation to the case, to the parent, to the network, to the team. There are a number of different ways to explore unconscious communication and encourage open responses such as using open-ended questions, eliciting stories from the participants and avoiding 'why?' questions. Additionally, the sample size is in line with Interpretative Phenomenological Analysis (IPA) methodology. The researcher was interested in how IPA picks up the unconscious communication, for example, in the pairs' relationship and how countertransference may appear, and to what extent their identities may impact this. Hollway and Jefferson (2013) note that the use of free association allows access to the participants' "emotional motivations rather than rational intentions", in psychoanalytic terms; access to the unconscious (p.34).

The research project aimed to investigate an aspect of therapeutic work that has been neglected in research literature. Pietkiewicz and Smith (2014) describe an IPA study as a "dynamic process, [in] allowing things to speak for themselves, [and]… through interpretative activity, make sense of the subject's personal world (p.8). There being little research on this area is surprising considering the child psychotherapy profession is focused on relating to the other and is part of group dynamic processes within a team.

Data Analysis Process

The researcher transcribed the interviews, then prior to analysing the interview data, used free coding to record and analyse their own reflections and thoughts on the research project so far. This included preoccupations about the interviews and subsequent coding process. Themes were then created from the free coding and used to inform how the researcher's personal feelings could influence the data coding. The interview data was analysed following guidance specific to the fundamental IPA principles with interpretation being central to the process.

Smith et al., (2009) suggests starting with initial free association, moving to descriptive comments then linguistic then conceptual. Smith and Nizza (2022) describe the individual case process in more detail as:

- creating exploratory notes on the participant's account
- identifying and formulating experiential statements
- clustering these into a logical structure/ finding connections
- constructing a table of personal experiential themes (PETs)
- cross-case analysis and constructing a table of group experiential themes (GETs) (p.32).

Ultimately, the process allowed the researcher to think about the data "moving from the particular to the shared, from the descriptive to the interpretive" (Smith et al., 2009, p.79). Smith and Eatough (2007) describe the analysis process as an iterative and inductive cycle, the researcher was aware that the route through the data would not be linear and at times rather challenging. The researcher started the process by reading and re-reading the interviews to get a sense of the individual's experience as well as each pair's experience.

As part of the exploratory notes, the researcher used the initial free-associating to note anything of interest on the right of the transcript, such as prompts or words including non-verbal behaviour, particularly nervous laughter, pauses and ineligible sounds. Further along into the process after much reflection, digestion and

interpretation from the researcher, experiential statements[4] were constructed on the left of the text. The next stage of the process focused on connecting the experiential statements and creating personal experiential themes (PETs)[5]. These themes were then analysed across all of the interviews and found to be recurrent across all or majority of the interviews. The final step of analysis was to conduct a cross-analysis of the PETs by interview to highlight the group experiential themes (GETs)[6]; which the study will focus on. The researcher noted which of these themes were recurrent across the interviews and found that they occurred across all of the interviews at least once.

Ethical considerations

Ethical approval for the research project was sought locally by the Tavistock's Research and Development department before submitting to the Tavistock's Research and Ethics Committee (TREC) for approval which was granted on 11th October 2023[7].

Protecting anonymity

Once participants were confirmed, the researcher sent them the participation information sheet again along with the consent form[8]. There were also physical copies in the interview room for the participants to read and sign before the interview started. All identifying details of participants, clinics and the families were anonymised for confidentiality reasons as the interviews were audio recorded. The audio recordings were transcribed onto a word document which was held securely on the NHS Trusts' computer system. The researcher analysed all of the transcriptions together in order to not be influenced by coming interviews.

The above has described what is termed as procedural ethics. As this is qualitative research using the IPA model, it is also important to also speak to ethics in practice

[4] See appendix 5: Sample of data analysis process.
[5] See appendix 6: Table of PETs
[6] See appendix 6: Table of GETs
[7] See appendix 2: Trust Ethical Approval Confirmation.
[8] See appendix 3: Public Facing Documents

or micro ethics, proposed by Komesaroff (1995). The term micro ethics has been used mainly in the medical field to distinguish 'big issue' bioethics with ethics in relation to clinical practice, that is, less with abstract ethical principles and more with the small, situated judgements embedded in the everyday conduct of clinical work. Guillemin and Gillam (2004, p.265) suggest that "a researcher must decide how far to probe a participant about a distressing experience". Whilst the researcher did not anticipate participants becoming distressed, thinking about patients who have experienced trauma within the frame of colonialism and intergenerational traumas can be an emotive topic. The researcher was also aware that there were some participants who would have experienced racism or similar discriminatory actions as the families they were describing. Participants were offered a follow up debrief information sheet[9] signposting them to various places for support.

All of the participants in the study were given pseudonyms to protect anonymity. Similarly, any other personal or identifiable aspects except race, class, gender and qualification status, which were required for the study, have been removed.

Participants by pair included:

Pair One: *p1a and p1b* (trainee-only pair).

Pair Two: *p2a and p2b* (trainee-only pair).

Pair Three: *p3a and p3b* (trainee-qualified pair)

Pair Four: *(p4a and p4b)* (trainee-qualified pair in the case / qualified-qualified in the interview).

Participant quotes are cited in the following format: interview and participant, page, line e.g. interview 2, participant a, page 1, line 23 - written as (p2a.1.23).

Power dynamics

Participants were encouraged to be reflective about their position as therapists in relation to their patients and one another, however the researcher was sensitive to the participants' emotional responses. The factors around recruiting four therapist

[9] See appendix 5: Debrief information.

pairs were also considered, including but not limited to, having both therapists in the pair agree to the interviews and the power dynamics that can arise between a trainee-qualified therapist pair. The researcher was aware that it may be difficult for trainees to speak in front of qualified clinicians, especially if they were also supervisors. The researcher also considered the impact of their presence as a trainee *and* clinician researcher interviewing their peers and/or qualified therapists.

Reflexive Statement by the Researcher

> *Reflexive research means that the researcher should constantly take stock of their actions and their role in the research process and subject these to the same critical scrutiny as the rest of their "data".*
>
> (Mason 1996, p.6).

> *They want to be conscious*
> *They want to do right*
> *They want me visible*
> *They want me out of sight*
>
> (Mackenzie-Mavinga, 2009, p.15).

In accordance with IPA methodology, this section explores and connects my experiences to the research process, from question design to interviews, transcription, and analysis. The opening quote by Mason (1996) encapsulates the aim of this section, whilst Mackenzie-Mavinga's (2009) poem excerpt reflects my feelings at the beginning of the process, in relation to my identity. Given the subjective nature of this section, it would be inappropriate to write about the impact of my identity in the third person, as doing so would suggest an objective or positivist stance. Gani and Khan (2024, p.3) describe reflexivity as enabling a questioning of one's interpretations, reliability, and the filtering out of distortions throughout the research process. This is essential, as I am aware that my "position and interests will influence all stages of the research process" (Pillow, 2010, p.273).

As this is qualitative research, I am interested in the “personal meaning people attach to their experiences” (Pistrang & Barker, 2010, p.67). This includes my experiences as a Black woman and a trainee child psychotherapist with an interest in mental health access for racially marginalised and minoritised communities. Moustakas (1990) aptly describes the researcher’s initial engagement as discovering an “intense interest, a passionate concern that calls out to the researcher, one that holds important social meaning and personal compelling implications” (p.27).

Alongside my personal interest, I was also aware of professional factors adding complexity. I am a trainee child psychotherapist interviewing colleagues within the same profession and NHS Trust. Although I had not directly worked with all of the participants, my trainee status created an inherent connection. I was conscious of the potential power dynamics between myself and both older and younger trainees. More significantly, I was acutely aware of the power imbalance between myself and the qualified CAPTS, partly due to the racial disparity as they and my research supervisor were mainly White. This awareness stemmed not only from my junior role but also from my identity as a Black woman and my relationship with the research question. The hesitancy reflected in Mackenzie-Mavinga’s (2009) poem mirrored my own anxieties about how the profession would respond to my inquiries into their thoughts and actions regarding racially marginalised communities.

Research is not only a way of learning about the world but also a means of understanding ourselves. I often discussed with my research supervisor the persecutory anxiety I felt about interviewing potentially defended subjects. Would my questions be perceived as judgmental? Could I challenge my qualified, senior colleagues? Might my responses cause the interview to shut down? These concerns, compounded by tight research deadlines, heightened my anxiety. To manage this, I maintained constant reflexivity through journaling, helping to separate my assumptions from participants’ narratives. This was crucial to prevent my subjectivity from becoming entangled in others' experiences (Denzin, 1997, p.27).

Interestingly, my initial focus on anxieties about defended subjects left me unprepared for other emotional responses, such as rage and mourning, particularly when hearing about patients' histories and racial trauma. At times, participants themselves expressed how these stories affected them, but my role as interviewer did not shield me from being deeply moved. Despite my adherence to IPA procedures, hearing about the impact of racism forced me out of my interviewer role and into the spotlight as a Black woman. This highlights a risk of reflexivity that Gani and Khan (2024) caution against; the vulnerability of the researcher, who may become emotionally entangled with the subject's suffering.

This entanglement was compounded by the difficulty of separating the patient's experience from that of the participant recounting it. In hearing about a family's experience of racial trauma through the account of the therapist or parent worker, I found myself responding not only to the participant's narrative but to the underlying experience of the patient being described, these layers of experience were not always easy to disentangle in the moment of the interview, or after during the analysis. This raised a methodological question about whose experience was being represented in the data, given that IPA is concerned with the participant's own sense-making rather than with the patient's experience recounted. In an earlier draft of this thesis, reflection on this difficulty was removed on the grounds that it risked shifting the analytic focus away from the participants and onto the patients' experiences, which fell outside the scope of an IPA study centred on the therapist and parent worker dyad. On reflection, however, I considered this difficulty itself to be a significant part of the reflexive account, since the tendency to slip toward the patient's experience is arguably characteristic of the patient-attuned position that child psychotherapists and parent workers themselves occupy, and its presence in my process offers a further point of connection with the participants in the study.

This experience echoes Fanon's description in *Black Skin, White Masks*, where he speaks of being overtaken by a "third person consciousness" (Fanon, 2008, p.83). Reflecting on this, Kareem and Littlewood's (1992) observation resonates:

“Most psychotherapists who are analytically trained learn to work with and understand the patient’s inner world and therefore there is resistance in dealing with psychological problems that originate in the real (outer) world. However most Black people would admit that the most traumatic feature in their personal lives is to be Black in a White society” (p.12).

Interview Data – Findings

Overview

The multilayered complexity of participants' thinking in relation to how trauma manifests in racially marginalised families is apparent from the interview data. Participants reflected on the work being influenced by a number of factors such as, their responsibility in the case, the emotional impact of the trauma, how difference was thought about, and the impact of external deprivation and realities in the psychoanalytic work. Perceptible anxiety was also noted throughout the interviews, including recurrent repetition of words, trailing off and nervous laughter.

The analysed interview data is described in three group experiential themes (GETs) This involved a systematic exploration and cross-analysis of the distinct personal experiential themes (PETs) that emerged for each data set, including interview quotes which enhanced this exploration. Due to the breadth of data, the researcher initially created seven GETs. However as is the nature of research, there were some inevitable casualties of this process and the final number of GETs was reduced to three. There are multiple, interrelated sub-themes for each GET, such as in *'Taking up the role: authority, containment and the working relationship'* there are sections on the trainee role and alliance which includes the experiences and responsibilities of being a trainee. Additionally, the GET '*Being with trauma: somatic and emotional responses in the dyad'* explores somatic responses and a section describing racial injury and trauma which is linked to the GET *'In the room: participants' experiences of sameness and difference'*

Free coding

IPA's approach to data collection encourages openness and flexibility, allowing the researcher to approach interviews without imposing preconceived ideas. Smith et al. (2009) emphasise the importance of "bracketing off any preconceived notions when designing and conducting interviews" (p.43). This methodological stance was crucial for the researcher, given their personal connection to the study topic. As a Black woman and a trainee CAPT, the researcher was mindful of how her identity and experiences could influence the research process.

Before conducting interviews, the researcher engaged in reflexive practices to acknowledge and manage potential biases. Reflecting on the dual role as both an insider (a trainee within the same profession) and an outsider (due to racial and experiential differences), the researcher considered how these dynamics might shape interactions with participants. There was a heightened awareness of the power imbalances, particularly when interviewing more senior colleagues. The researcher anticipated possible challenges, such as receiving negative or defensive responses, and the difficulty of addressing them within the interview context.

Additionally, the researcher was conscious of the emotional impact of her proximity to the research question. As previously mentioned in the reflexive statement, Gani and Khan (2024) highlight, reflexivity involves not only examining one's interpretations but also managing emotional responses that arise during data collection. The researcher experienced moments of uncertainty and anxiety planning the question, due to the possibility that participants might tailor their responses to align with what they perceived as the researcher's expectations. This aligns with Hollway and Jefferson's (2013) discussion on the relational dynamics in qualitative interviews, where participants' motivations and perceptions of the interviewer can influence the data collected. In psychoanalytic terms, this could also be understood as an example of the researcher projecting her own anxieties and preoccupations onto the research participants. The main themes which overlapped with the interview data were connected to the researcher's identity such as:

- The trainee role - hesitancy, taking up role.
- Power dynamics within the interviews.
- Who has authority / expertise on the topic?

The process of free coding, therefore, was not only about identifying themes in the participants' narratives but also about being attuned to how the researcher's presence and perspective might shape these narratives.

Personal Experiential Themes

The IPA analysis explored a number of PETs taken from the experiential statements for each interview. During the cross-case analysis there was a recurrence of feelings of despair, hopelessness and overwhelm connected to the family's trauma; power dynamics within the network, the relationship with the family and with each other. The PETs are grouped below by interview:

Interview One	Interview Two
- The trauma was hard to be with - Sameness/ difference had a big impact. - Aware of being a trainee. - CP and PW had a good relationship / coupling. - Differences in opinion about the treatment - Relationship to the family.	- Emotional response from the trauma - Closeness/ distance linked to race? - Difficulties being a trainee. - Trainee alliance in the case. - The service's response to the family / treatment. - Child psychotherapy can feel neglecting of external realities. - Difficult relationship with the family.
Interview Three	**Interview Four**
- The experience of trauma is violent. - Racial differences was a factor of the case. - The trainee role. - Trainee and supervisor dual role. - The impact of therapy. - Acknowledging the rigidity of psychoanalysis / staying within a frame. - Good relationship with the family.	- Emotionally overwhelmed by trauma - Racial difference was hard to think about. - Being a trainee was difficult. - Trainee referring to supervisor for information. - Is the therapy helpful or harmful? - Psychotherapy model was helpful / tensions staying within it. - Close relationship with family

Pair makeup repeated here for ease:

Pair One: four months of weekly child psychotherapy and parent work ongoing

Mixed Black boy	White mother
White woman	Black woman

Pair Two: six months of weekly child psychotherapy and weekly parent work for two years ongoing

Black boy	Black grandmother
White woman	Black woman

Pair Three: two years of weekly child psychotherapy and fortnightly parent work, recently ended

Black boy	Black mother
White man	Asian woman

Pair Four: three years of intensive child psychotherapy and parent work, ended two years ago

Black boy	Black father
White woman	White man

The PETs identified in this analysis reveal the emotional, relational, and systemic complexities faced by the participants. Key issues such as emotional overwhelm, cultural dynamics, trainee challenges, and the limitations of the psychoanalytic model were recurrent across interviews.

Group Experiential Themes

The researcher chose three group experiential themes (GETs) by the end of the analysis by grouping the personal experiential themes under overarching umbrella themes. During this process there was some difficulty in neatly fitting each PET into a GET; this reflects the complexity of interviewing pairs and working with differing views simultaneously. The themes have been laid out in a systematic way to highlight the journey and experiences from the internal, individual to relational and then external. This layout best captures the experience of IPA working as close as possible to the lived experience of a subject and then widening the gaze (Smith and Nizza, 2022). This approach also reflects the experience of a child psychotherapist in

the transference with a patient, whilst also being aware of their own feelings and the external family and network.

The group experiential themes are listed below. For ease of reference, each theme will be referred to in the following abbreviated format throughout

- A: –**Being with trauma…** participant somatic responsesracial trauma and mobilisation and evacuation
- B: **Taking up the role…** – the trainee identity, taking up authority, the trainee alliance, and working as a team
- C: **In the room…-** the psychotherapy model and difference, sameness and difference.

Theme A: Being with trauma: somatic and emotional responses in the dyad.

The researcher was curious about the impact of historical, cultural and intergenerational traumas, between the participants, and how they specifically understood and explored this which would ultimately impact how they worked together. Participants spoke about the trauma reaching all areas for themselves and within their dyad, such as mentally, emotionally, physically and externally within the family relationships, network and psychotherapy frame.

The most notable experience shared by the participants was an overwhelming feeling of despair, which they connected to their proximity to the trauma in the work.

> "*I felt so hopeless handing over from the parent worker, like what have I picked up, this is bleak..BLEAK!"* (p1b.12.360).
>
> *"She was so overwhelmed. It's a lot of work. And she felt it… felt like she was doing it on her own. You know, like that as we talk about it, I feel like it's, I don't want to feel like it's this and this and this, endless. But it felt endless" (p2b.*6.204).
>
> *"I suddenly found myself being really, like, emotional and I was like. I feel like I'm not like I can't believe how, you know how highly they've?... I'm left feeling really guilty."* (p2a.30.998).

> *“There's so much trauma that you like… I don't, I don't remember that. But I remember, like, you would be meeting with her and you'd have sessions. And then every now and then you'd hear something really shocking.”* (p3b.3.87).

> *“I can remember coming back to the clinic and being in an absolute flood of tears, thinking this is, you know, feeling it's just so incredibly painful and frightening, actually.”* (p4a.27.912).

> *“I think it was palpable, really, that and people felt overwhelmed by the sadness about what had happened to him and how lovely he was.”* (p4a.11.353).

One participant reflected on her own sense of alarm as she understood that the child’s deterioration in presentation was due to being separated from his teaching assistant he has grown attached to after many years. The participant expressed her frustration at witnessing this shift later reframed by the school as the child simply “making bad choices” (p1b.29.859) with no space given to what had been lost. Another participant in a different pair described her own discomfort in recognising how much informal labour had quietly come to rest on a grandparent carer once exclusion became a possibility, work the participant felt fell outside the therapeutic frame yet went unacknowledged by the network around the family. A third participant recounted her own shock at noticing a shift in how professionals around the family had come to perceive the child, from a boy to “*this dangerous sort of almost psychiatric Black man… rather than a boy having a tantrum”* (p3b.11.347).

Some participants described finding a way to hold onto their feelings of despair, which became a source of motivation to remain committed to the work.

> *“We need to do this and there's this real sense of urgency. That really got into me and I promised all sorts.”* (p1a.20.577).

> *"I do sometimes genuinely feel quite, like, hopeless about everything and then a bit helpless and then genuinely so disappointed. And then I'm like, no, I have to. I've got to get back into the fight and like, oh, I've got to be the one that holds on to something that she can't at the moment."* (p1b.36.1105).

> *"So there were many times where you would have probably thought this is just not working…I remember being very clear that this was a case where they had been dealt too many bad cards, and it was our duty to be tenacious… and keep hold… you've got a moral imperative, and this case certainly was like that."* (p3b.8.255).

> *"There was another lady who was also, she had a pastoral role. But her office was below the therapy room, she was brought in quite out of her role actually. She did a lot to help with the kind of management practically like getting both children to the session, particularly my patient who would be in and out and in and out down into the nursery up, you know, on the stairs, you know. So I relied on her a lot to help me with that, although it wasn't really her job to do that."* (p.4a.14.482)

At other times the trauma was so overwhelming it evoked a different response from participants, such as paralysis and at times distancing and evacuation.

> *"Also, where's our anger? We're saying about the family and the anger and J's anger, but, when we sit here and talk about the school and the holiday, you know, I can feel it, but then it doesn't quite get mobilised into anything. I'm not sure what it is that it should have been mobilised into…"* (p2a.19.608)

> *"It was my first experience of working in that sort of way...I can remember thinking this is, you know, feeling it's just so incredibly painful and frightening actually... I think that I felt very paralysed at times actually."* (p4a.27.908)

> *"I think there were times where I sort of felt quite paralysed to know quite how to to share my thoughts with him. And then less so overtime I think…"* '(p4b.30.1008)

In response to question 9[10], the participants were able to explore more acutely the psycho-somatic and transferential experience of working in the presence of trauma.

> *"There is something about him getting really close, and then, like, physically, it does make me feel warm. But then there's also sometimes I feel a bit scared*

[10] Have there been instances where you have had a response about the case that could be linked to unconscious dynamics? Such as a body response (tense, fidgety, distracted) or a feeling towards the child/ parent, therapist / parent worker.

> *that he might hurt me or that he's gonna throw something at me. So there's kind of a warmness and then also there's like, a unpredictability that "ohh something might just happen, and he might."* (p1a.35.1091)

> *"Feeling like I'm getting it all wrong, like the transference basically, and my countertransference. I think that leads to like a bit of dread... But then there's also moments where he really tries to kind of show his sweetness and his care… and then I feel so like moved, and like, guilty that I've had all these kind of feelings of dread for seeing him."* (p2a.31.1035).

> *"I was getting on my little Brompton to go to the school… There was something very kinetic about it… The needing to keep going… I had transported my body to this place and was there with him and we were together in these different, you know, throughout it, I suppose and that felt important."* (p3a.25.798).

> *"I don't know if I felt anything in my body, apart from heart palpitations… and I mean, I would feel, you know, more emotional states, but acutely so... I'd feel really furious or just really distressed or really perplexed or really anxious, or really puzzled. They were all the extremes of every emotion."* (p3b.26.833).

Some of the participants reflected on, and at times questioned how their respective teams had come to the decision for particular treatment choices, and wondered if the families' trauma had an impact on these decisions:

> *"I wonder if anyone thought about putting them two together and doing the work because, I think that is the work. But that is not the plan and that wasn't considered." (p1b.15.463).*

> *"There was an expectation that they would do family therapy and individual therapy. And also, X has started her own therapy outside of here… It was very overwhelming for for them."* (p2b.5.158).

Many of the participants reflected on the tension of staying within a psychoanalytic or psychotherapy frame whilst also trying to manage external realities of trauma and deprivation.

> *"We strayed from the model to try and meet his needs." (p3b.21.664).*

> *"I think taking up the position as a child psychotherapist does sometimes feel like neglecting the external sort of realities, and um, yeah, I that can feel quite hard. And sometimes even the kind of like the way that we boundary our work puts limitations on how much some families can engage with the work."* (p2b.34.1139).

There was some acknowledgement of using the psychotherapy frame as a steering guide for the work, despite the trauma:

> *"...so there's all these different parts having to be alive to these, you know, different parts all the time and allowing him in the context of that holding all these different parts to just sort of grow as a boy… and protect him… we felt the trauma."* (p3a.28.906).

> *"The work was about sort of being up like being a proper boy, sort of getting into latency… I remember feeling quite cross cause I thought, no get up off. You know, you can do it. You know you need to come out off the floor and up and have a go."* (p4a.48.259).

Participants also reflected on the difficulty of trying to hold a frame when the therapy was online[11]. They shared mixed feelings about how online psychotherapy could meet the patient's needs:

> *"It was all really confusing online, particularly because he was older, so I went and I was trying really hard to have something that resembled a kind of, you know, frame online."* (p4a.16.551).

> *"I remember when he was at home, and we were doing it online. And I'll come for supervision and just talk about how like it feels like harmful to do that. It feels like cruel to sort of meet with him and it is it's sort of tantalising, you know to sit like that."* (p3a.21.655).

Theme B: Taking up the role: authority, containment and the working relationship

This theme is central to the research study, as all participants reflected on their relationship in the dyad. The trainee role was also highlighted within the participants' dynamic. Due to the pairing combinations, the trainees made up the largest number

[11] For p4a the therapy oved online to support the family in attending therapy, for p3a the therapy was moved online due to the Covid-19 social distancing policy at the clinic.

of participants. There were two trainee-only pairs and two trainee-qualified pairs. Thus, the data included six trainee experiences. The researcher also being a trainee made for an interesting dynamic in the interviews, especially depending on which year of the training the participants were in. Of the six trainee participants, one was in the same year of training as the researcher, two were in more advanced years, and three were in earlier years, a range that introduced varying degrees of relative seniority and familiarity into the interview dynamic.

This dynamic was noted in the second interview with a trainee-only pair, earlier on into their training. Here, the anxiety appeared to stem not only from the shared experience of being trainees interviewing one another about their clinical work, but also from the disparity in seniority between the researcher, a more senior trainee, and the participants, who were earlier in their training. The participant who commented on this was in her first year, and her reflection suggests that this gap in experience may have shaped how she related to the researcher in the interview, alongside the more general self-consciousness of trainees interviewing each other about clinical work. "*but also, I think there's something about, like relating to each other slightly differently, as interviewees and interviewer, that feels… (ineligible/ small laugh)…"* (p2a.1.23)[12].

Anxious feelings related to the trainee role recurred throughout all of the interviews. The trainee participants reflected on not being able to take up their authority in their roles as child psychotherapists and parent workers which impacted the relationship in the dyad. Interestingly, this was understood by the researcher as a transferential communication, mirroring dynamics present in the wider case. This was also partly influenced by the clinical complexity and severity of the cases, which could feel overwhelming and left less space for trainees to assert their authority due to the trainees' voices not being fostered within their service.

> *"I wasn't part of any of that process as well and it felt very strange like when I. So, I have to say the way I was given my parent work*, *I I have questions about that because it was sort of like 'you just do them.'"* (p2b.12.399).

[12] Participant quotes are cited in the following format: interview and participant, page, line. (eg interview 2, participant a, page 1, line 23)

> *I just get given the cases, like I don't feel like I have any kind of, because I'm a trainee, like, you just have to take the cases that are given to you." (p2b.20.647).*
>
> *"I also feel like I have no authority, but it's hard to know if that's because you know, I'm so early on in my training that I just don't know what I'm doing."* (p2a.27.910).
>
> *"...but it didn't feel like maybe you were 100% on board when you, when you're a first-year trainee and someone says it's time to close the case, you're like… OK." (p1a.10.267)*

Additionally, trainee participants reflected on the experience of being allocated complex cases early in their training, describing feelings of inadequacy, uncertainty and overwhelm:

> *"… it was sort of right at the beginning of my placement starting, he was kind of my second case, you know, within a few weeks. I didn't really understand how assessments worked at all, didn't understand what we would offer or not."* (p2a.11.377).
>
> *"It was my first case. My first patient on the training, first intensive, plus the pandemic, plus everything else. I think a lot about how I would have done that differently. And actually, I think I felt very overwhelmed as, as indeed did he."* (p4a.9.286).
>
> *"It did feel difficult. I remember feeling like, oh, I thought a qualified person had to take it…." (p1a.11.311).*
>
> *"…in terms of our relationship and working as a couple at that time, I remember because I think I was brand new as a trainee. But also, I remember when we were working like that that you had, you were holding so much of the sort of oversight..."* (p3a.5.149).

Self-conscious feelings from both trainees and parent workers/ supervisors about presenting in the training supervision outside of the clinic were also noticed:

> *"I used to feel a bit like, oh, I'm going to go to supervision with the same session as last time (small laugh). You know a lot of that kind of feeling."* (p4a.18.570).
>
> *"He was in his first year of training and he would be going to supervision groups. And they'd be like 'you're doing what?!'" (p3b.9.277).*

The interviews highlighted a distinct role difference between the child psychotherapist and parent worker, which at times overshadowed the trainee or qualified status. This also links to the trainee's experience feeling they have a lack of agency; however, they also had an experience of being held and protected by either the parent worker or the senior therapist.

> *"I feel like there's so much that goes on that I don't know about, like the adults in my head, like, it's the adults, like the case coordinator, the family worker at the school, like, they're all the adults in the case. And I'm just, I'm just like here to work with X, basically"* (p2b.20.631) ... *"I feel like that's so much but like, you're one of the adults to me."* (p2a. 20.639)

> *"…I feel supported and understood by you anyway, like when we talk about other cases and stuff. But I do think on this case is it's really challenging working with him and you know, you can feel like you've made progress and then he'll come back and it will be like really really difficult, everything is upside down, and I do feel like you give me containment." (p1a.36.1115).*

> *"So, there's a bit of me that feels like this is like we have contact about it regularly and I feel really supported as in, I think… I I'll ask you for advice and you give it and…" (p2a.24.795).*

Participants reflected on how they worked together in the case, majority of the time this was as a team:

> *"I was just thinking though, something else that I think happens maybe is happening a bit with us is like, I never have contact with the care coordinator… but I I tend to come to you... I think that's because, you know, I see you a lot and I value your opinion."* (p2a.17.562).

> *"I was very grateful that he could just hold a bit steady and, and sort of respect that I might be onto something, even though at times I didn't really know. I just knew that we kinda had no choice but to carry on."* (p3b.24.752).

> *"We were very close before… It feels like we're like in this together and we have this agenda. I don't know if that's right or wrong, but we have this agenda to help them, and mum knows this. She can feel it. She says 'I know you and X are doing everything' … It feels like we're a team… We're like such a strong team and we are not having it, we're going to supervision, and*

> *people are picking up on our coupling and sometimes we're getting backlash."* (p.1a/b.18.556)

At other times there was an apparent tension between whose needs were prioritised in the family:

> *"I remember when he was at home, and we were doing it online… I think I was perhaps full of despair at points and I think you were having to sort of receive that in supervision…. So I wondered at points where I was quite unreasonably just coming in sort of hitting you with that without any way forward really, so to speak."* (p3b.21.677).

> *"I think we all had quite strong identifications with our respective person in the, in the three probably at one stage or another."* (p4a.24.806).

> *"So I think where you might have felt more concerned, I was probably more able at times to hear it and sometimes less able to hear it because of this kind of oscillating feeling of wanting to think with Dad, but… wanting to protect him a bit."* (p4b.45.845).

Theme C: In the room: participants' experiences of sameness and difference

All of the participants reflected on how sameness and difference, relating to race, gender and class, were thought about and experienced in the work. Participants were working with families from Black or mixed African or Caribbean backgrounds, with latency age boys as the identified patients. This context shaped how race, class and gender were experienced and explored in the dyad, Racial and class sameness and difference was touched on by all of the participants and evoked a range of feelings in them. They reflected on how these dynamics shaped their own engagement with the psychotherapy model and their interactions with the wider network.

Reflections on the psychotherapy model explored if it allowed thinking around race, culture and difference; from recognising the impact a rigid psychoanalytic stance would have on the family, to expressing frustration at the lack of thinking within the team. A participant shared her experience during a service supervision:

I wanna think about it and what's happening and it's like the response is kind of like 'I want you to feel freer to not have to know and not have to think about this too much'. If I was coming to you with an Oedipal complex, of a four-year-old middle class child, you'd be like, 'I've got all sorts of ideas here.'" (p1a.38.1182).

Whilst another spoke about the analytic model not being suitable due to the tentative relationship she had with the parent. This tension is noted within the literature review for therapists to exercise care in how they apply their language and metapsychology to their patients (Fanon, 2008; Dalal, 2002; Lijtmaer, 2006.

> *"If I'd gone and made it about her and done that more analytic thing, I think I would have lost her."* (p3b.16.520).

Considering the model, one of the pairs noted how difficult it was for the family to accept the treatment that was offered. The therapists were aware there was an assumption that the family would experience the treatment offer as an expectation. This dynamic resonates with the mistrust and fear Jackson (2022) identified as recurring themes affecting Black families' access to and engagement with CAMHS services, suggesting that the family's caution here may reflect a broader, racialised experience of services as monitoring or judging rather than simply offering help. As the participant reflected:

> *"He felt that there was this thing that we were offering him, which we thought was helpful. He couldn't quite understand why it needed to be so intense. But if he were to say no, that would be an indication of something that we might then use to demonstrate that he's not doing what he should be doing."* (p4b.22.708).

Despite recognising this dynamic and its links to race and class, the participants reflected on their own difficulty in creating space for these concerns to be named. One participant reflected that the family had gone along with what was offered without raising the questions or differing feelings they may have had, recognising in their own practice that, in their words:

We kind of offered too much because we wouldn't normally offer, expect families to do all those things, you know. And and she kind of agreed to everything but it got in a real confusion you know." (p2a/b.11.360).

Some participants reflected on the racial or class similarities they shared with the families, and how this influenced the relationship and discussions they could have.

> *"She came to me and saidThis is probably what happened before with his dad… because he's Black. He's a Black boy. That that's how they see him". And I said yeah, I think you know I understand that*…" (p1b.23.694).

> *"They were talking more specifically about their worries and their anxieties about raising Black children in London. Me being a Black person as well, perhaps, may have allowed them to speak more explicitly to those things."* (p2b.14.480).

> *"I do wonder whether there's something about race and maybe class that came into it. And I think it's interesting when you took on the parent work… I said 'ohh X is gonna be seeing Mummy now' and he said 'oh is she Black, is that a Black name?' That was the first time that he'd ever concretely said anything about race. And then, interestingly, I kind of tried to explore that, with him and and I kind of spoke about me being White and what that might mean. He was like, 'oh, I thought that maybe you might be mixed race'… like him."* (p1a.7.169).

However, some participants shared that at times the sameness reflected in the relationship with the families was emotional and painful, as the participants could relate to the discrimination and racism the families were experiencing, which in part was related to or caused the trauma. This caused a tension in the participants, trying to balance their professional role with the painful personal realities of experiencing discrimination.

> *"I think when I'm with her, that's probably more really where I'm from… than when I'm in the professional world, that's my background. That's who… I grew up in a council estate. Sorry it's actually making me really emotional… (voice cracks, tears up)... that's me… I feel bad. I feel like I can see why she is misunderstood and that's the people I grew up with…" (p1b.25.750).*

> *"I think I feel connected to X. But in ways that I sometimes don't want to feel connected to her. And I think that's what is sometimes hard… (voice breaking, tears up)... That I get a lot of the pain that she's, you know, that she brings to the work. I can. I totally feel all of it."* (p2b.30.1012).

Whilst being aware of differences, some participants felt it difficult to name or hold onto this with the families. There was a sense of avoidance from the therapists and the families in addressing it.

> *"I was more wondering in terms of masculinity, I suppose, more, sort of maleness. But actually probably would have been more helpful to at least also or perhaps more think about it in terms of my Whiteness… I often thought that she really didn't know what to make of me as like a person in his life."* (p3a.17.563)

> *"I think it is happening all the time and I think like the fact that I'm White and I'm a woman is you know, obviously in the room. But I think erm it's hard to locate it or notice it… there's a lot of time looking out of the window rather than kind of being in the room, but a lot of time is spent noticing the differences between the White and the black cars in the carpark."* (p2a.13.457).

> *"If there's something about like being really scared of the authority, because what that would make me as a White person treating a Black boy, a White woman treating a Black boy, you know. And their experiences of racism and my fear of authority, you know, of like, being authoritative. What that would do, and so almost being like so aware of our difference…"* (p2a.27.910).

> *"I did feel that at times with Dad that offering my thoughts to him or trying to sort of share what I was thinking about could really feel like a sort of a White man telling a Black man that he knows how to think about something and that I really don't think that's where I was coming from in my intention. But I do think that something of that never quite got sort of thought about properly between us… when we did get to a stage where we could sort of address our differences, at least on a sort of more superficial level, Dad would then say that he didn't think it was sort of relevant to go into it."* (p4b.31.1046).

> *"I'm also thinking that, you know, of 'Black Lives Matter', at the time you know, George Floyd all of that stuff, which I I never took into the work at that time… I sort of feel a bit…. I just be a bit a bit ashamed and a bit surprised at myself, in retrospect that all of those things were there… I didn't, maybe I didn't know how or I didn't feel I could or or. I'm not sure why really, but this little boy who*

> *undoubtedly might have needed some help thinking about those things."* (p4a.32.1079).

This avoidance also related to the participants who were aware of their sameness but also the nuanced differences that were present in the relationship with the family:

> *"I think I've been able to sort of say, you know, obviously you're Black, I'm Black, and maybe these things feel sort of easier to say here and that sort of thing… but are there things that she feels she can't bring to me because I'm a younger Black woman?"* (p2b.27.889)

Alongside the therapeutic work, participants shared the difficulty of managing the overt and hostile racism that was being enacted by the school and wider networks connected to the families.

> *"They are trying to kick him out…We're talking about the exclusion, the school to prison pipeline essentially." (p1b.30.932)*

> *"If there is some kind of unfair treatment of X's behaviour say that is racially you know, motivated or you know there's some kind of discrimination going on there. It doesn't feel like [the family are] able to say, you know, they're kind of really trying to be on their best behaviour with services." (p.2a.10.341).*

> *"He's recently started to eat lunch in school with everyone else…he was sitting in the room on his own… I think the worry is if she isn't cooperative with the school what will happen?... we talked a bit about kind of race, haven't we and how that's playing out in the school." (p2a/b.10.321).*

> *"We were entering this sphere of realising that the school were, were being actively racist, I think we we were like in the run up to that we were both feeling really confused, really overwhelmed, really bewildered." (p3b.26.845).*

One participant noted that the racism and anti-Blackness experienced in the network was being enacted by staff, taking particular note that they were from Arab and Asian backgrounds.

> *"It felt like there was an identification with him being a Black boy and us feeling horrified by what we were seeing and feeling a kind of a responsibility..*

> *the SENCO was Arab…and and the the exclusion officer was also a Muslim woman, but it just felt like there was an act, a, a conscious, a subconscious act of racism… I didn't even think it was unconscious, really, because it was extraordinary." (p3b.10.329).*

Some participants also acknowledged the similarities and differences between themselves as the therapists:

> *"We do have to be aware of the twinning thing and being like "we have no differences at all!"* (p1a.39.1209).

> *"We were three White workers working with that family."* (p4a.2.61).

> *"I felt very aware about being the only woman in the dynamic, particularly because of my, you know, because of maternal transference."* (p4a.19.604).

The participants also reflected on their relationship with the family as a whole and their respective patients. As one would expect, the impact of race, class, gender and trauma had a large influence on how the family related and connected to the therapists and experienced the therapeutic relationship. Similar to sameness and difference, another polarisation: closeness and distance was often mentioned by the participants. For example:

> *"I do also think she feels like I'm very alongside her in terms… I think she feels that generally that, I get that."* (p1b.4.77).

> *"I think initially there was more of a distance that was kind of like you know, I don't know. And I think it was. There was a distance and I think she maybe felt, I think she mainly just felt incredibly worried that I'd be judging her."* (p1a.32.990).

> *"Like I still feel very much like we're very far away. We're just getting to know each other, even though it's been quite a long time."* (p2a.7.238).

> *“I don't feel settled and it feels, even though I know she appreciates the parent work and all the rest of it… It's hard to feel like we're in this.”* (p2b.29.967).

Participants also reflected on their impression of the family, the relationship and how they experienced the therapy:

> *“We would just have a different relationship… there has always been this sort of loveliness to him that has saved him, I think in lots of ways.”* (p3a.17.583).

> *“I might end the conversation and be like, ‘hang in there X, this is tough, but we’ll get through’ It was like a lifeline felt like for her.” (p3b.*27/856).

> *“I said, and I think you know that you don't need a hug either to know that we are close to to each other in our minds.” (p4a.*7.233).

> *“He's very bright… also very charming… such a lovely man…I would have loved to have been friends with him. You know, he would have. I think he he would have been a lovely man to have as a friend.”* (p4b.13.442).

Discussion

This section will explore the GETs in more detail, linking them to the data, literature review and research question. The themes have been ordered to take the reader on a journey from the internal and individual (being with trauma), to the dyadic relationship (taking up the role), and finally to the external and collective (in the room).

Despite the small number of participants, the analysed data yielded an abundance of rich and sometimes polarising experiences. Participants shared the difficulties they faced in holding families with trauma and the impact this had not only on their own relationship as co-working therapists but also on their relationship with the family. Feelings of guilt, anxiety, dread and overwhelm recurred across interviews, with each dyad managing these feelings differently. For some, the emotions mobilised them to hold steady in a fractured system; for others, this led to paralysis and an ‘anti-thinking’ state. These emotional processes directly shaped the therapist–parent worker dynamic, the very focus of the research question.

Three themes were drawn from the data, though more could have been identified given the complexity and layering of difference and trauma in this context. It was difficult to separate these two aspects, as racial trauma formed an underlying experience across cases. Other areas of interest emerged that lay beyond the scope of this study, such as the patient’s direct experience of the treatment or the therapist’s relationship with the wider family system. Yet thoughts about how the psychotherapy model addressed, or failed to address, trauma and difference repeatedly surfaced. A common experience described by participants was a wish to do something helpful and healing in these traumatic situations whilst feeling hindered by the model or frame. During the analysis, the researcher continually returned to questions directly linked to the study’s aim:

- *How do we know what we are picking up in the room from patients is related to them or us?*

- *How do we distinguish between the impact of the trauma and the impact of a model that does not sufficiently address these issues?*

The process of identifying and incorporating the GETs was at times overwhelming due to the complexity of the participants' experiences and the cases they described, the findings made clear that racial trauma was a significant and specific factor shaping the participants' experience of the therapist-parent worker dynamic. The researcher also reflected on the structure of psychoanalytic training, which often treats topics such as 'difference and diversity' and 'early trauma' in separate modules. This may have influenced the initial tendency to separate 'difference' and 'trauma' in the study, when in practice many participants were describing racial trauma experiences being re-enacted across the wider network. This interplay between trauma and difference is precisely what the research question sought to illuminate.

Theme A: Being with trauma: somatic and emotional responses in the dyad

> *"It was palpable… people felt overwhelmed by the sadness about what had happened to him…"*
>
> (p.4a.11.353).

This theme is significant as it speaks directly to the research question, exploring the experience of the child psychotherapist and parent worker dyad in working with trauma in racially marginalised families, and how this experience may be linked to dynamics present in the case itself. This study explores participants' experiences of working with trauma in racially marginalised families, and how these experiences may illuminate the therapist and parent worker relationship, within a predominantly White and middle-class profession.

Themes A and C are closely related but have been separated for clarity. However, this division does not diminish the pervasive presence of racial trauma, which was evident across all cases. The participants were usually open about how they felt in relation to the trauma without the researcher having to ask. The researcher wondered if this was due to the significance of the trauma presentation, alongside case presentations being central to child psychotherapy training.

The data also revealed the participants' experiences of closeness and distance; between each other, with the child or family, and within the wider network. These dynamics appeared to be largely shaped by the participants' experience of the trauma in their cases but were also influenced by the therapists' relationships with one another, the broader network, and experiences of sameness and difference.

All participants described moments of feeling overwhelmed with despair whilst working with their respective families. The trauma present in these cases seeped into the therapeutic dyad, evoking feelings of bleakness, fear, guilt, and shock. The literature on intergenerational transmission of trauma highlights how trauma is often

projected from parent to child as a means of displacing unbearable emotions (Klein, 1946; Barth, 1998; Rustin, 2009). In this context, such projections could also occur between patient and therapist, and between parent and parent worker within the transference, offering therapists a direct, emotional experience of the families' collective and historical pain.

Somatic responses

As presented in the findings section, participants described a range of physical and emotional responses whilst working with their cases, including heart palpitations, kinetic energy and being in floods of tears. Dass-Brailsford (2007) outlines four areas of functioning impaired by trauma: emotional (including shock and anxiety), cognitive (disorientation and hypervigilance), behavioural (irritability and repetitive movements), and physical (elevated heart rate and fatigue). All participants described at least one of these responses, the in the findings which highlighted a somatised response to the transference felt or held in the body.

The researcher was curious about how the therapists understood somatic responses and whether these reactions influenced the dynamic between them, their respective patients and themselves. One participant's reflection spoke to this directly, describing a sense of despair arising in relation to the case, which he recognised, on reflection, as having been unfairly placed onto the parent worker rather than processed within himself, illustrating how an emotional response to the case could come to shape the dynamic between the dyad in ways not immediately apparent to either party. Additionally, the theme of closeness and distance echoed throughout all interviews. Most of the participants described similar experiences of feeling warmth, alongside dread, fear, and guilt within the therapist-patient/ parent relationship. This raised the question for the researcher: What is the significance of the closeness? In pair two, this experience was felt by the parent worker, where the closeness or connection with the carer was due to a shared experience of racial trauma. This connection, however, served as a painful reminder and was ultimately unwanted.

Reflecting on Fanon's (1952) and Lijtmaer's (2006) descriptions of fragmented identity, where negative racial experiences or cultural instability disrupt identity formation, can help explain the participants' conflicting feelings of warmth and dread. It could be understood that there was confusion and fragmentation in how the boys' identities were perceived, leading to a split; they were seen as warm and sweet, yet also violent and frightening. As Pick (1985) suggests, "the child's projective identifications are actions in part intended to produce reactions: the first thing that happens inside a living object into whom a projection takes place is a reaction" (p.158). The researcher wondered whether participants had introjected these dynamics and how this might have shaped their countertransference responses within the dyad. It is possible to speculate that this introjection also shaped participants' feelings about power differences within the dyad itself, with unequal authority between the two roles unconsciously coming to echo the family's own transference to power and difference.

As evidenced in the findings section, pair three described an immediate and visceral response upon meeting the family, including a palpable feeling of despair. Drawing on Reisenberg-Malcom's (1999) ideas, this response can be understood as the therapists trying to make sense of the family's communications Both the child psychotherapist and parent worker reported psychosomatic responses whilst working with the family. The parent worker described it as heart palpitations, feeling emotions acutely and the therapist described a kinetic energy in his body. These responses seemed tied to their need to remain mobilised and activated for the family, a response to absorbing the families' experience in the countertransference. Maharaj (2021) further notes that power and oppression can be imposed and internalised as a "bodily felt experience", distancing individuals from their "organismic self" (p.124).

Reflecting on the transference, the researcher questioned how one could sit with a family so entrenched in deprivation and not absorb some sense of that experience. The researcher wondered whether these intense responses reflected what was absent in the family as described by pair three as appearing to be depressed, beaten

down, and despairing. This highlights the profound emotional impact on participants when working in close proximity to trauma, and the ways in which they may unconsciously carry parts of that experience within the dyad.

Racial injury and racial trauma

Whilst this section aligns more closely with Theme C, which focuses on difference, the researcher felt it was essential to explore the injury and trauma resulting from racism within this theme. The findings describe that three out of the four pairs encountered overt racism directed at the families they were working with, which they had to hold and manage within the dyad. Handford and Marrero's (2022) framework is particularly relevant here, as it helps to contextualise the emotional burden participants described in holding and responding to these experiences, although it was not always held equally within the dyad. The parent workers in pairs one and two specifically described feeling more drawn into the families' experiences of racism due to a shared racial identity. Most pairs described instances of racism and discrimination that the families were experiencing during their work together. These incidents were often perpetuated by schools or the wider systems the therapists operated within. There was also an acknowledgment that these Black and mixed-heritage families faced racism in their everyday lives. Mohatt et al. (2014) describe historical trauma as complex and collective, experienced over long periods and across generations by people who share an identity, affiliation, or circumstance. Jackson (2022, p.78) argues that when the "vulnerability and needs of Black children are met with exclusions from school and society, we are in desperate need of reform." When we consider this alongside current realities, such as worsening socioeconomic conditions, migration, and persecution (Tsiantis, 2000), it becomes less surprising that the families' presentations often felt bleak and despairing.

Trauma literature offers frameworks like secondary traumatic stress (STS) and vicarious trauma (VT). STS is the emotional strain from helping or wanting to help a traumatised person (Figley, 1995). VT arises from indirect exposure to trauma through firsthand accounts or narratives (McCann and Pearlman, 1990). Whilst this research does not aim to diagnose or pathologise the therapists' experiences, these

concepts provide useful lenses to understand how participants experienced the transmission of trauma within their relationship.

Three out of the four pairs discussed overt racist treatment the families endured at school, which compounded the issues presented in psychotherapy. Handford and Marrero (2022) define racial injury as an “individual’s internal and/or external distress in response to a racist event”, whilst racial trauma is described as “being psychologically traumatised from the event” (p.6). The three pairs noted both implicit and explicit forms of racism, which they had to manage amid tense relationships between schools and parents/carers. A recurring experience shared by all families was the pervasive fear that something would happen; that the school would enact a racist attack or exclude the children. For the therapist and parent worker dyads, holding this fear alongside the family meant carrying an additional layer of responsibility, managing not only the clinical material but the wider network's racial dynamics, often without a clear sense of where that responsibility began or ended between the two roles.

Conversely, whilst the family in interview four did not experience overt hostility from the school, the father was very aware of their racial identity and perception by school and CAMHS. He was worried that the school, whilst well-meaning in trying to offer support, were pushing his son down a stereotypical ‘sports’ route as an alternative to supporting his academic learning. Whilst the father was able to voice this with the parent worker, something else was located in the CAMHS system - his fear that they would report him if he did not comply with the treatment plan. For the dyad, this split meant that each therapist came to hold a different piece of the father's anxiety, the parent worker receiving his more articulated concerns about the school, while the therapist and wider network became the unconscious repository for his fear of surveillance and punishment, requiring the dyad to bring these separate pieces together in order to make sense of the family's experience as a whole.

Racial trauma operates on multiple levels, including individual, communal, and systemic, and its impact varies depending on familial, historical, and socio-political contexts. In the three pairs where families experienced racial injury and trauma, the parent workers were racially Black and Asian. This raises a critical question: Are frameworks like STS and VT fully applicable to racially marginalised therapists who share a collective experience of racial trauma with the families they work with? As seen in the accounts of the parent workers in pairs 1 and 2, who described feeling more drawn into the families' experiences of racism due to a shared racial identity they faced unique emotional demands that their White colleagues may not encounter (Mohatt et al., 2014; Handford & Marrero, 2022).

Mobilisation vs Evacuation

The interview data revealed two distinct countertransference responses when participants were confronted with the families' trauma: *mobilisation* - becoming highly engaged, going above and beyond to support the family, or *evacuation* - withdrawing, avoiding emotional engagement, or becoming paralysed and unable to think. These reactions can be understood within the framework of transgenerational trauma, which, as Gentile (2017) notes, "reproduces within cultural domains as carried by race, class, and gender" (p.169). The researcher was curious about whether these two responses directly impacted the working alliance and if they were often the same or differed within the therapist's dynamic. For example, pair one were both actively involved in the case and worked together as a team. In contrast, while pair three was also deeply involved with the family, their relationship revealed underlying power dynamics. Furthermore, pairs two and four exhibited periods of paralysis and withdrawal in relation to the case and appeared to be the least coordinated of the therapist pairs. This point will be elaborated upon on page 76 and in the subsequent sub-theme "*Working as a team".*

Pairs one and three illustrated the mobilised response. They described feeling an intense emotional pull to "hold on" and do everything possible for the family, often going beyond the scope of their roles. This sense of duty wasn't isolated; they noticed that other professionals in the network also felt compelled to act. Pair four

reinforced this, highlighting how school staff became similarly activated, showing remarkable resourcefulness, often overextending themselves to support the family. This mobilisation often stemmed from an emotional identification with the family's helplessness and despair, which activated a moral imperative to help.

An awareness of racial trauma likely intensified this response. As Handford and Marrero (2002) observe, "there is a link between racism and discrimination and psychiatric symptoms including depression, anxiety, and PTSD across racial and ethnic groups" (p.8). For therapists attuned to the impact of racial trauma, such as pairs one and three, the urgency to act may feel even more pressing, driven by an understanding of the compounded layers of suffering these families endure.

The act of evacuation is especially significant when considering the impact of racial trauma within these therapeutic relationships. For therapists, particularly those from racially marginalised backgrounds, working with families who share similar experiences of racial injury can evoke complex and conflicting emotions. This was present in pair two where the parent worker at times felt paralysed by the emotional burden of the trauma. Although this was also present in pair four, there was no racial similarity, but what the therapist described as a maternal transference which put her in touch with feelings of loss adding to the paralysis. In these moments, evacuation may serve as a psychological defence, protecting the therapist from the unbearable weight of both personal and vicarious trauma. Interestingly within all of the pairs, they had a similar response - either both mobilised or both passive, which mirrored the relationship with the family.

This raises important questions about the emotional toll on therapists and the need for reflective spaces, such as supervision, that can hold these complex dynamics. Supervision that is attuned to issues of race, power, and trauma becomes crucial in helping therapists process their own somatic and emotional responses, reducing the risk of evacuation or over-identification with the family - this is particularly crucial for therapist-parent worker dyads. Moreover, it highlights the importance of systemic awareness within therapeutic networks, ensuring that the emotional labour of

managing racial trauma does not fall disproportionately on therapists from racially marginalised backgrounds.

Theme B: Taking up the role: authority, containment and the working relationship

"You were so instrumental for me in that supervision meeting" (p1a.11.319).

This theme is central to the research question, as the working alliance between the therapist and parent worker is the primary focus of the study. It encompasses considerations of power dynamics within the network, the impact of trauma, and the relational dynamics within the interview room itself. The subsections in this theme include the trainee identity, taking up authority, the trainee alliance and working as a team to provide a cohesive narrative and understanding of the complexities in the child psychotherapist and parent worker dynamic. The researcher also questioned how far the participants were aware of their relationship mirroring something of the families' dynamic.

Drawing parallels with Brodsky's (2017) concept of the triadic nature of supervision, the researcher reflected on the triadic dynamics present in the interviews. Considering supervision groups, they typically involve senior clinicians acting as supervisors, alongside at least two practitioners and/or trainees as supervisees (Scanlon, 2002). The composition of each interview varied which influenced the dynamics. In interviews one and two, three trainees were present; in interview three, there were two; and in interview four, only the researcher was a trainee. These differing configurations affected the relational dynamics in each interview. The trainee-only pairs spoke openly about their dynamic and often appeared more aligned than the trainee-qualified pairs. However, all pairs expressed gratitude towards each other for their collaborative efforts in managing the case. Whilst this positive portrayal can offer pleasant working environments, it could have also been influenced by the pair interview format, where it might not have felt entirely safe to critique the other therapist, particularly if one was qualified.

The literature review touches upon aspects of this dynamic, especially concerning the supervisory relationship, which was notably relevant in interview three. Regarding Lee and Thackery's (2023) research, which explored power dynamics in group supervision, draw parallels to the dynamics observed in these interviews. They highlight that "when psychotherapists bring themes, issues, and behaviours from therapeutic work into supervisory settings (Gediman, 2001), parallel processes may drive the reenactment of the therapist-patient relationship (McNeill and Worthen, 1989)" (Lee and Thackery, 2023, p.124). This insight suggests that similar parallel processes may have been at play during the interviews, influencing how the participants interacted and reflected on their cases. The researcher particularly noted in interviews one and two that they were initially treated as a peer but felt at times they were operating in a supervisor capacity, similar to peer supervision. In interviews three and four there was less opportunity for three-way thinking and the researcher remained in an interviewer/ observer role.

The trainee identity / having a voice

As highlighted in the findings, the trainees across all four pairs described significant difficulty in finding their voice and taking up authority in their roles. Notably, this was voiced openly even in the presence of the trainees' more qualified colleagues, without apparent reticence, a point returned to later in relation to gender and authority within the dyad. The most notable comments from the interviews highlighted the difficulty trainees faced in finding their identity and feeling empowered to share their opinions within their teams. This struggle often transferred into the cases they discussed, with the researcher noting how the participants' own experiences of feeling disempowered mirrored dynamics present in the wider network. It was difficult to talk about feeling disempowered or persecuted. Many participants described feeling overwhelmed, with their trainee status significantly impacting their confidence in managing their respective cases. Most of the trainees spoke explicitly about the challenge of having a voice in these cases. Pair two discussed being assigned cases without consultation, leading them to feel they had no choice but to accept them, similar to the family's experience in the case. This dynamic within the service or supervision seemed to influence their difficulty in

asserting authority in their cases. Wilson et al. (2016) noted that such powerlessness could lead to stress and self-doubt, often internalised as "it must be what I am doing. It must be my fault" (Nelson and Friedlander, 2001, p.291). This sentiment was particularly relevant to pair two, highlighting the struggles trainees face in establishing their professional identity as child psychotherapists.

The trainees in pairs three and four, where both cases had ended, were openly able to share their discontent and despair about aspects of the case the parent worker was holding. This openness may have stemmed from the unique relationship between the trainee and the parent worker. In pair three the parent worker was also their supervisor. Additionally, the supervisor's identity as a mixed Asian woman and the trainee's identity as a White man may have influenced their dynamic, allowing for a different level of openness compared to other pairs, where the women trainees (Black and White) had men as supervisors. Specifically thinking about gender, Heru et al., (2004) found that female supervisees are often more guarded in sharing with their supervisors compared to males. The researcher acknowledges that other visible and invisible identity characteristics such as race, class, sexually and disability would have a further influence. Regarding pair four, the trainee was newly qualified, and the parent worker had not supervised the case. In addition to the case ending two years prior, the researcher wondered if this changed the power dynamic structure from when they were working on the case.

Trainees frequently expressed a lack of confidence in their roles, when discussing their cases. The researcher wondered if this was case specific or could be thought about more broadly with children and families from low socioeconomic backgrounds, with migration experiences, and/ or family traumas. Despite support from supervision and their teams, trainees often felt inadequate and at times believed that a qualified child psychotherapist would be better suited for such cases. Tsiantis (2000) highlighted this issue decades ago, noting how increasing needs and decreasing resources exacerbate these challenges, leaving families with minimal external support by the time they reach CAMHS. Trainees, therefore, often found themselves

managing external factors such as organising 'team around the child/family' (TAC/TAF) meetings and liaising with social care, housing or education. These added pressures contributed to the overwhelming nature of their roles. Whilst this is an ordinary part of care coordination in CAMHS, it can be daunting for trainees who are holding particularly complex cases as described by all of the participants in this study.

Taking up authority

Pair two repeatedly discussed the difficulty of taking up their authority in their roles as child psychotherapist and parent worker. This struggle was likely influenced by their early stage in training and a lack of confidence in sharing their thoughts. The data also revealed how trauma and racial dynamics affected their ability to take up authority. One trainee was conscious of her position as a White woman, and hesitant to appear authoritarian with a child of a different race. Conversely, the other trainee questioned if her racial similarities with the parent/carer hindered the therapeutic relationship. These hesitations reflect Fletchman Smith's (2011) notion that authority is shaped by who holds it and how safely it can be exercised. This also highlights the complexity of power dynamics within the work as the hesitations could also be linked to the position as a trainee.

Racial dynamics played a role in most of the cases, particularly with the trainee parent workers, both Black women, who felt that they couldn’t fully express the impact of racial trauma within the transference but also in their personal lives. Interestingly this echoed not only the experiences of the father and grandmother who had reservations about the treatment plan but struggled to voice this, but also similar in Jackson’s (2022, p.82) study where the White teacher “believed he was offering something good, but this father could not be certain” Davids (2011) discusses how racially, or ethnically marginalised communities may internalise external perceptions, losing their voice in the process. Supervision spaces that address and explore the impact of racism and trauma on relational dynamics (McKenzie-Mavinga, 2009) could provide crucial support for trainees.

Additionally, pair two was highly aware of the limitations of their roles as child psychotherapists, perceiving the psychotherapy model as rigid and ill-equipped to address external deprivation. In contrast, pair one navigated authority differently, forming a strong alliance that sometimes led to ‘coupling up’, a dynamic explored further in the ‘*working as a team*’ section. The parent worker in pair one noted the therapists struggle to advocate for herself and the case, highlighting an environment where voicing opinions felt challenging.

In pairs three and four, trainees faced challenges in external supervision, grappling with differing opinions between their clinic and academic supervisors. Brodsky’s (2017) triadic supervision model highlights the complexities of these dynamics, where the clinical and academic supervisors hold distinct power and influence, impacting the trainee's experience. This was particularly evident in pair three, where the parent worker and supervisor were aware of how the academic supervisor perceived the case, contributing to the trainee's sense of despair. In pair four, the trainee shared her dismay at bringing the same type of session write ups to her supervision group. This not only highlights the pressure for this treatment process to work, but also the tension between the child psychotherapy frame in theory and reality. This acutely mirrored the father’s questions about the need for intensive child psychotherapy, which speaks to the unconscious communications held within the case.

The trainee alliance

The relationship between the trainee-only pairs significantly influenced their experiences. In pairs one and two, trust and alliance played critical roles as they felt able to collaborate without the hierarchical dynamics present in qualified partnerships. However, the nature of their alliances varied. Pair one exhibited a strong, outward alignment, sometimes at the expense of broader team dynamics, referring to themselves as a ‘couple’, which drew question from their supervision group. They felt united in their mission to help the family, viewing themselves as a

‘strong team’. Interestingly, this was also present in the interview, the researcher at times found themselves in the position of the third, managing a conversational and collaborative atmosphere, with a pull to offer peer supervisory reflections.

Pair two highlighted a different dynamic, they maintained a passive stance, reflecting feelings of overwhelm and had a tendency to distance themselves from the trauma within their case. In the interview, the trainee pair relied on the researcher to prompt who would answer next. Although, their alliance was rooted in their shared trainee status and regular contact, the parent worker struggled to accept their role, hoping the broader network (referred to as ‘the adults’) would manage it. This passivity meant they approached the case from a distance, with minimal contact, allowing them to remain aligned as trainees. Interestingly, this mirrored dynamics within the case itself, where the school often relied on the carer to ‘clean up’ after incidents or emotional outbursts from the patient. This passive position may have served as self-protection from the overwhelming trauma but ultimately limited the dyad’s capacity to engage fully with the work, repeating the pattern of leaving the family to bear the burden.

In both interviews one and two, the level of deprivation and trauma experienced by the family directly influenced how the pairs related to each other. In the first pair, the trauma led to extreme mobilisation and coupling, whilst in the second, it resulted in passivity and emotional evacuation. A parallel process was at play in the therapists’ relationships, though they seemed unaware of it. Despite the presence of racial differences between the parent worker and therapist in both cases, only pair one explicitly addressed their dynamic, which appeared more influenced by their trainee roles and the mobilisation within the case. Whilst they were aware of their external differences, this did not hinder their strong ‘twinning’ identity.

This dynamic also mirrored the relationship between the parent worker and the parent. The researcher considered the multiple reasons for this coupling, including the impact of institutional racism. The parent and child were targets of the school’s

racism and classism, which echoed the parent worker's own interactions with the school system.

Psychoanalysis emphasises the role of the 'third', as being an observer or witness to the patient's profound histories and trauma. However, the researcher was acutely aware of the impact of collective trauma, which can inhibit the capacity to occupy "a location of witnessing and thirdness... the space between meaning and experience" (Gentile, 2017, p.172). During the interview, pair one reflected on their coupling and how it at times prevented them from positioning themselves outside of the families' experiences. In some instances, the supervision space was experienced by the trainees as a hostile 'third' to resist. This dynamic may also reflect the trainee alliance and the complex dyadic/ triadic relationships between trainees, supervisors, and services.

Working as a team

As described in the findings section, participants reflected on the importance of working together as a team in their respective cases, though this was not always achievable- especially when they became overly identified with the needs of the child (patient) or the parent. This difficulty was particularly evident in the third and fourth pairs, which the researcher suspects also reflected underlying power dynamics between the trainee and qualified child psychotherapist.

The third interview was unique in featuring a trainee-qualified pair where the qualified child psychotherapist also served as the trainee's supervisor. This dynamic was apparent in the interview: the trainee expressed reverence for the parent worker's role in holding the case steady, whilst the parent worker conveyed gratitude for the trainee allowing her to do her job effectively. These responses reinforced the notion that the parent worker was positioned as the 'adult' in the case; a role that pair two had referenced. The clear delineation of roles in pair three allowed them to collaborate effectively, despite the trauma and deprivation present in the case. This

sense of stability was absent in the trainee-only pairs, potentially contributing to their feelings of uncertainty and anxiety.

Participants also noted that the parent/carers could sense when the pair worked cohesively as a team. Magagna (2022) discusses how the unconscious and conscious dynamics between supervisor and trainee can influence, and be influenced by, the child-therapist relationship. Similarly, Searles (1955) suggests that “processes at work currently in the relationship between patient and therapist are often reflected in the relationship between therapist and supervisor” (p.135). In this study, these dynamics also extend to the parent worker–therapist relationship, which can impact interactions with both the child and the parent / carer.

Pair two’s case was the only one involving kinship care, with the grandmother as the primary carer. The researcher wondered what painful feelings might have been associated with closeness in this case, as there was a noticeable emotional distance between the therapists. By the end of the interview, the participants expressed gratitude for having a space to come together and reflect deeply on the case and its emotional impact. They left with practical tasks and aimed to come together and take up their roles. The researcher questioned whether this level of openness and curiosity was available to them in their usual supervision.

The research also explored how the pairs recognised and managed disagreements or negative transference within their dynamics, whether related to the case or not. Interestingly, the trainee-only pairs tended to focus on issues within the network, whereas trainee-qualified pairs were more able to discuss interpersonal challenges between themselves. This difference could be attributed to the trainees’ positions or their external relationships, which may have influenced their ability, or inability, to recognise and address issues within the pair dynamic. A recurring aspect in the interviews was the question of whose needs were being prioritised within the family. Pair four, for example, described how identifying too closely with the family sometimes hindered their ability to think together as therapists. As at times, this

identification created a tension within the dyad, making it difficult for the pair to think together clearly. As the parent worker shared, he at times overlooked parenting concerns raised by the therapist.

Additionally, both trainees in pairs three and four discussed the challenges of offering online therapy and the sense of despair it provoked as they attempted to ‘hold’ a virtual space. Both trainees were able to share their frustration and despair about conducting therapy online in the interview. Highlighting the emotional strain of trying to maintain a therapeutic frame in this setting. It’s important to note that in these cases, the therapy had already ended, which may have allowed the trainees’ feelings of deprivation and frustration to settle, offering them capacity to think more openly. A different response might have emerged had they still been actively engaged in the case.

Both of the participant’s reflections on online therapy underscored broader tensions explored in the study - specifically, the challenges of adhering to rigid therapeutic models that may not meet the complex needs of families or therapists. The findings suggest that fixed frames can sometimes exacerbate feelings of deprivation and disconnection, especially in cases of significant trauma or in contexts that limit authentic team collaboration.

Theme C: In the room: participants' experiences of sameness and difference

> *I think when I'm with her, that's probably more really where I'm from… than when I'm in the professional world, that's my background*
>
> (p1b.25.750).

As previously discussed, this theme is deeply interwoven with the others explored in this study. However, for the purpose of the research, it is essential to examine it through its own lens. This theme has been divided into three sections: *'The Psychotherapy Model and Difference', 'Sameness',* and *'Difference'.* Interestingly, all of the families in this study were Black or mixed-race families from African or Caribbean backgrounds. The researcher reflected on this, as participation was not restricted to Black families, but rather '*non-White*'[13] families. This raised a question about whether participants had implicitly understood '*non-White*' to mean *'Black'*, and whether the researcher's own identity as a Black woman had consciously or unconsciously shaped how participants engaged with and interpreted the study. The data highlighted key questions for the researcher when thinking about difference:

- *What are we (as therapists) bringing to the interactions?*
- *What are the consequences if we don't acknowledge this?*

By engaging with these questions, the hope is that therapists will cultivate a deeper awareness of both themselves and their patients. As Hardy (2018, p. 23) suggests, therapists must become "curious about their clients' lives and the process of therapy but [also] curious about themselves as well. They begin to ask as many self-reflective questions about themselves as they may ask clients".

[13] see Introduction: NB change of identity term.

The psychotherapy model and difference

Most participants reflected on the challenges of working within a child psychotherapy or psychoanalytic frame. The parent worker in pair three highlighted the balance needed when working with traumatised parents who are not able to take in reflective comments. They realised the impact of an analytic stance would have disrupted or broken down the parent work. Similarly, the first pair noted a lack of space to think about difference in their supervision. The trainee, a White woman, expressed frustration at her supervisor, a White man, who wanted to 'free her up' from having to think about racial differences. This prompted the researcher to wonder whether this response was rooted in White privilege and whether a trainee from a racially marginalised background would have been offered the same advice. Thinking about difference is not a burden one can simply set aside. Turner (2017) suggests that when therapists fail to work through their privilege, it creates a psychological barrier between themselves and their clients. Additionally, Mckenzie-Mavinga (2016) argues that "therapists who ignore the challenge of racism contribute to the perpetuation of racism and inadvertently contribute to the client's pain about oppression" (p.212).

Pairs two and four reflected on their experience of how the psychotherapy treatment was perceived by the families. Both pairs noted that their respective services responded to the trauma and deprivation by offering substantial support and reflected on the tension this created in the work. Pair two observed that their family silently accepted the treatment options, despite feeling overwhelmed. They recognised that, under normal circumstances, they wouldn't typically offer multiple interventions at the same time. Pair four similarly noted that the father expressed discomfort at the combination of parallel parent work and intensive psychotherapy for both of his children yet felt unable to decline. This was a dynamic the participants reflected on with concern, recognising the power imbalance.

These examples highlight the complex experiences of racially marginalised communities accessing mental health care. Whilst the services aimed to offer support, believing their approach was helpful, the issue lies in how participants experienced the families' perception of the support, and what this revealed about

how authority operates in these contexts. (Fletchman Smith, 2011). One could argue that the services unintentionally set the families up for failure by providing more than they could manage. In both cases, there appeared to be a lack of collaborative decision-making, or an understanding of how the families perceived their difficulties (Kareem, 1992). In line with some of the literature reviewed earlier, this can be viewed as evidence that the families were excluded from the decision making due to a lack of shared language (Fanon, 2008; Dalal, 2002; Lijtmaer, 2006).

Davids' (1993) assertion that "it is not possible to understand a patient's experience without knowing something of the context" is particularly relevant here (p.274). The background literature also addresses issues of perceived authority and the lasting impact of colonialism on therapeutic frameworks (Fletchman Smith, 2011; Fanon, 1952). It could be argued that both families, not wanting to be labelled as uncooperative, accepted the treatment plans despite only one voicing reservations (Arnold, 2014, p.119). The researcher wondered if the father (interview 4) was able to do this due to being a man, compared to the grandmother (interview 2) who had a similar relationship with the school being demanding and dismissive. Davids (2011) describes this dilemma: "...you walk away into a comfort zone of belonging… either you fit in quietly with what is expected of you… your very silence supports the notion that Black [people] are fair game for racial abuse, or you rebel" (p.5). Notably, once these power dynamics became apparent, neither dyad appeared to challenge the treatment plan itself. It is possible to speculate that the family's own sense of powerlessness entered the dyad via transference, leaving the therapist and parent worker similarly unable to assert a different course of action. Alternatively, this may also reflect the hierarchical structure of CAMHS, the child psychotherapy profession or training needs specifically, in which treatment pathways are not easily revised in response to the particular needs of individual families, especially where difference has not been actively thought about within the system.

The participants seemed unable to critically reflect on why the families perceived what was intended as a helpful offer as an obligation. In pair four's interview, whilst the focus was on the boy child, the other sibling was also seen as an intensive case.

This raises a crucial question about the child psychotherapy model: was this extensive offer truly in the best interest of the family, or was it influenced by the service's training needs?

Sameness

The racial and class similarities between the parent workers and the parents/carers in pairs one and two evoked strong emotional responses during the interviews, often leading to cracked voices, pausing and tearfulness. These reactions highlighted the shared, collective experience of discrimination, as discussed by Mohatt et al., (2014).

Whilst this section focuses on sameness, it's essential to acknowledge the differences between the parent workers in pairs one and two. Both were Black women from different countries in the Caribbean and Africa, and both reflected on how their identities shaped their experience of the work. Despite variations in country of origin, age, and life experiences, the shared experience of parenting a young Black or mixed-race boy from a working-class background had a profound and painful impact on the parent workers. Additionally, the parent worker in pair three of mixed Asian heritage, was acutely aware of the institutional racism happening in the school and was more able to speak to it with the parent and network. Tang and Gardner (2014) found that therapists from racially marginalised communities are often more able to discuss issues related to race than their White counterparts. This was echoed by the parent worker in pairs one and two who reflected on whether their identities as Black women helped or hindered the parents/carers in expressing concerns about discrimination more openly. This raises a further question about the dyad relationship itself, whether the parent worker's greater proximity to the family's racialised experience positioned them as the primary holder of this material within the dyad, potentially leaving the White psychotherapist more distant from, or less attuned to, this dimension of the work, with implications for how evenly this aspect of the case was shared and thought about between the two roles.

In pair one, this dynamic was particularly evident. The therapist working with the child noticed that the parent worker being a Black woman enabled more explicit

conversations around sameness and difference. This struck the therapist, a White woman, as she had been attempting to address her racial difference with the child for some time. She noted that the parent worker's race and name allowed the child to acknowledge their identity for the first time and discovered that the child assumed the therapist shared his mixed-race identity. This moment highlighted how racial identity can shape the therapeutic space and influence what is brought into the conversation. This was an interesting illustration of how the wider dynamics can influence the therapy.

Interestingly, in the same case, race was also acknowledged by the White mother during parent work sessions. However, the focus of this conversation was on the racial similarity between the parent worker and the father and son. Yi (1998) suggests that "racial minority therapists are more cognizant of race and of the impact of race on therapy than White therapists" (p.252). The parent worker, who had replaced a previous White, middle-class therapist, was aware of her racial difference to the mother, but noticed a stronger sense of connection through their shared working-class backgrounds. The class similarity provided a foundation for deeper conversations, eventually allowing the mother to discuss the racial discrimination her son faced. Hall (1990) describes cultural identity as a "point of identification" that reflects both a politics of identity and position (p.226). In this case, the researcher wondered whether class provided a stronger initial bond between the parent worker and the mother, leaving racial differences unexplored, possibly due to what Tang and Gardner (2014) describe as "an anxiety associated with racial prejudice" (p.90).

In addition to racial and class similarities, participants also reflected on the role of gender. The parent worker in pair four spoke about his experience working with another man and reflected on the possibility of friendship. This comment stood out, as he was the only parent worker who described his therapeutic relationship this way. The researcher wondered about the unspoken racial dynamics, the father was from an African country that had suffered under British colonial rule, and worried that if he did not comply with treatment, he would be reported. The researcher wondered if this was the reason the pair could not explore or engage in more challenging

conversations about their racial differences, despite the parent worker attempting to address it.

Tang and Gardner (2014) argue that addressing differences too early in therapy can close off the space where the patient is able to use phantasy to explore feelings of connectedness to the therapist. The researcher acknowledges that addressing difference depends on each case and the unconscious dynamics at play between patient and therapist. However, the researcher also wondered if the discussion about racial differences would have “condensed scary impulses” that the parent worker may have formed counter resistances to if fully acknowledged (Holmes (2014, p.65). However, it is also important to recognise the parent’s emotional capacity to engage in reflective work, the parent worker was aware he did not want to challenge the father any further than he felt he could manage.

Difference

As described in the findings section, participants described significant difficulty in explicitly naming and exploring difference, both within the dyad and with the families. For most participants, the primary focus when discussing difference was in a racial capacity, though some also reflected on class and gender and how these factors may have shaped their relationships with the families they worked with. Interestingly, only a few participants explicitly addressed these differences and the impact it had on the therapeutic dynamic. One example came from the therapist in pair four, who noted being the only woman in the network and linked this to a maternal transference she held. However, this reflection was framed within the therapy’s context and the relationship with the child, particularly heightened by the mother’s bereavement. There was no exploration of how this dynamic affected the therapist herself or the therapist-parent worker dynamic. The researcher speculates this may have been influenced by the parent worker’s presence in the interview, making it difficult to fully articulate what it felt like to be the only woman in the dynamic.

The literature on psychoanalysis and race remains limited, often focusing on the White therapist's relationship with Black patients, which has some relevance here. A recurring theme in this literature highlights the importance of recognising transferential responses related to racial or ethnic differences (Altman, 2006; Greene, 1985; Littlewood, 1988). Komakech (2023) supports this view, as their research found that these feelings could shape clinical perception directly, with Black patients sometimes perceived by clinicians as impulsive, aggressive, or lacking insight, alongside feelings of superiority and hostility towards them. All of the participants attempted to explore this in their interviews but noted an avoidance when it came to explicitly acknowledging these differences with the families or between themselves, often struggling to locate or name them.

In pair two, racial difference was present but unspoken in the therapy room. The therapist described difficulty in getting close to the child, which the researcher understood as connected to the trauma present in the case and its impact on the therapist's countertransference. The therapist described feeling so acutely aware of racial differences that it left her paralysed, unable to act. Although the child brought it in through the play, the paralysis may have further contributed to the emotional distance. Tang and Gardner, (2014) have a view that conversations about racial difference should emerge from the patient's curiosity, interest, or conflict, rather than being introduced solely for technical reasons. However, the researcher wondered what role this silence played for both the therapist and the child; whether it served as a protective barrier but also reinforced the distance they struggled to bridge.

Additionally, the parent worker in pair four was conscious of how his role as a White man advising a Black father could be perceived but found it difficult to fully address this dynamic as the father did not think it was relevant. This contrasted with his earlier comment about how their relationship might have evolved into a friendship outside of the work context, suggesting a complex mix of connection and distance shaped by race and professional boundaries. Meanwhile, the therapist in the same case expressed shame over not raising the topic of race, particularly in the context of Black Lives Matter protests happening globally at the time, reflecting a tension

commonly described among White therapists working with racially marginalised patients. Neither the parent worker's difficulty naming this dynamic with the father, nor the therapist's shame about her own avoidance, appeared to have been shared or thought about between the two of them, each seemed to carry a version of the same difficulty, avoiding race, individually, rather than the dyad recognising this as a shared pattern requiring joint reflection. This suggests that whiteness itself may have functioned as an unspoken, shared position within the dyad, one that shaped both members' relationship to race in parallel ways without becoming available for mutual thought. Yi (1998) notes that White therapists often experience guilt and shame when confronted with the racial traumas experienced by racially marginalised patients. Tang and Gardner (2014) argue that this guilt is rooted in White privilege, where the therapist's own racial stereotypes can evoke discomfort and countertransference challenges (p.90).

Differences beyond race also played a significant role in the therapeutic dynamics. In pairs two and three, the therapists described difficulties aligning themselves with the parents. Whilst part of this could be attributed to the inherent difference in the therapist-child relationship, a bond the parent isn't privy to, the study also highlighted more complex intersections of difference. Even where participants did not explicitly name these dynamics as affecting the dyad relationship itself, the analytic process pointed to their presence within it. Consistent with IPA's double hermeneutic, in which the researcher's interpretation sits alongside participants' own sense-making, these difficulties in aligning with parents appeared, on closer analysis, to have a bearing on how the therapist and parent worker related to one another, whether through one therapist unconsciously compensating for the other's difficulty, or through unspoken tension in the pair's shared understanding of the case, even where participants themselves had not consciously articulated this as a dynamic between them. In pair two, there was racial similarity between the therapist and mother but a class difference, leading her to feel judged and perceived as incompetent by the therapist and the professional network. In pair three, multiple layers of difference - race, class, and gender, intersected. The therapist was initially more attuned to his maleness than the racial dynamics in the relationship making it harder to fully hold and explore the complex interplay of identities at work.

Limitations

Whilst this research offers valuable insights into the impact of race, class, and gender in the clinical work on the therapist-parent worker dynamic, it has some limitations. Including the sample size, researcher positionality, methodological challenges, and the complexity of exploring issues of difference in therapeutic settings.

Sample Size and Representation

Due to the nature of qualitative research, it is expected that this study would have a small sample size, however it makes up for this in the quality and depth of experiences that can be explored. The study focused on a limited number of therapist-parent worker pairs who chose to discuss Black or mixed-race families from African or Caribbean backgrounds. This meant that the study did not include families from other racially marginalised backgrounds. The researcher wondered if this was due to a number of reasons such as lack of referrals within the service, the researchers position as a Black woman or how participants perceived the term “non-White”. The researcher also acknowledged that due to the time pressure of the research schedule, it was not possible to recruit alternative participants with cases from racially marginalised communities. The inclusion of participants who had worked with non-Black families from racially marginalised backgrounds might have produced subtly different findings. Whist the focus allowed for a deep exploration of race and identity in therapy, the focus on Black families potentially limits the generalisability of the findings. This would be an important area of exploration for future research.

Researcher Positionality and Bias

The researcher’s identity as a Black woman inevitably shaped the research process; she was acutely aware that the participants may have modified their responses, consciously or unconsciously, based on assumptions about the researcher’s identity

and expectations. Furthermore, it could also have introduced bias in data interpretation, for example by prioritising certain themes due to the researcher's personal experiences and perspectives. Despite the use of reflexivity and regular research supervision to mitigate this, the researcher is aware that complete objectivity in research is unattainable. However, the inevitable subjectivity of the researcher is valuable, guiding deeper inquiry and fostering meaningful interaction with participants.

Methodological challenges and the complexity of transferential dynamics

The main focus of the study was exploring the complex transferential dynamics at play between the therapist-parent worker themselves, rather than the dynamics either therapist held individually with the child or parent.

Whilst some participants reflected on their countertransference and the impact of their identity on the therapeutic frame, others struggled to articulate these processes leading to gaps in some of their reflections. This avoidance mirrors broader societal discomfort with race discussions and may have limited the richness of the data. The choice of IPA, with its emphasis on participants' own sense-making alongside the researcher's interpretation, allowed these dynamics to be explored to some extent even where participants could not articulate them directly, though the depth of this exploration remained dependent on what participants were able or willing to put into words. Additionally, the presence of both parent workers and therapists in the interviews may have affected some participants' willingness to fully explore their own biases or difficulties in the work, particularly when power dynamics within the professional setting were at play.

The depth and nuance of such dynamics are difficult to capture through interviews alone, despite the semi-structured approach and the researcher's position as an observer at times. One to one interviewing has seen to be the preferred interview method as it allows the interviewer and interviewee to build up a rapport, allowing more space to think and answer freely (Reid, Flowers, & Larkin, 2005). However, the researcher was able to observe the pairs interact and used their countertransference

to explore possible experiences/ dynamics in the network. Longitudinal methods, which were out of the scope of this study, may have offered further insights into how these dynamics evolved over time.

Implications for clinical practice

The findings of this study have a number of implications for clinical practice, training and supervision within child psychotherapy and CAMHS more broadly.

Supervision

The study highlights the need for supervision spaces that are attuned to the conscious and unconscious dynamics at play in the therapist-parent worker dyad, particularly when working with racially marginalised families. Participants described how the emotional and somatic impact of working with racial trauma was not always able to be contained within existing supervision structures. As suggested in the literature review, supervision that actively creates space to explore the impact of race, power and trauma on the dyad would better support therapists in processing these experiences, reducing the risk of mobilisation, evacuation or over-identification with the families. This is especially important for therapists from racially marginalised families who carry additional layers of emotional labour that require specific acknowledgement in supervision.

Since submitting this thesis, the researcher was approached to offer a consultation to two trainee psychotherapists working as a therapist-parent worker dyad as the work was on the verge of breaking down. The work involved a family with complex, intergenerational traumas, and the cultural and ethnic similarities between the therapists and the family added to the tension and discord the therapists experienced within their dyad. They could not communicate to each other effectively, and these difficulties were not able to be fully addressed in their supervision. Since offering this consultation, both therapists reported that the space had helped stabilise the working relationship and prevented the therapeutic work from breaking down. This suggests a recognised need for this kind of support in practice. Reflective

groups and consultation spaces as a complement to individual supervision, could offer valuable space for this kind of thinking, allowing practitioners to process the collective and systemic dimensions of the work alongside their personal responses.

Training

The findings suggest that psychoanalytic training would benefit from a more integrated approach to race, trauma and difference. Participants described how these themes are often treated as separate modules within training, which may inadvertently reinforce a tendency to separate what in practice are deeply intertwined experiences. Training that equips supervisors to better understand the impact of dyad dynamics on their supervisees, not just within families, including the power differentials between trainee therapists and qualified parent workers, would better prepare therapists for the relational complexities of this work. This includes developing supervisors' capacity to hold and name, racial, class, gender and other identity dynamics within the supervisory relationship itself, rather than treating these as peripheral concerns.

Case Allocation

Interestingly, this study also points to the importance of more thoughtful case allocation at the outset. Several participants described being allocated complex cases early in their training with little preparation for the specific dynamics this would evoke. A more considered approach to case set-up, one that acknowledges the potential dyad dynamics from the beginning, including the supervisor/supervisee pairing where relevant would better support both therapists and the families they work with. This might include pre-case discussions between the therapist and parent worker, as well as their supervisors to anticipate and name the dynamics likely to arise, not just with the families but also between themselves.

The Psychoanalytic Model

Finally, the findings raise questions about the flexibility of the psychoanalytic model when working with racially marginalised families experiencing significant social and economic deprivation. Participants repeatedly described tension between staying

with the therapeutic frame and responding to external realities of their cases. This tension may, in part, reflect a broader hierarchy within the profession, in which 'pure' psychoanalytic work is often implicitly valued above 'applied' approaches, with adaptation to a family's lived circumstances sometimes regarded as a dilution of technique rather than a considered clinical response to need. Reframed in this way, flexibility need not be understood as a departure from psychoanalytic rigour, but as a positive adaptation in service of the family in front of the therapist. A more adaptive approach, one that retains the core psychoanalytic principles of attending to unconscious processes, whilst remaining responsive to lived realities of racially marginalised families would better serve both clinicians, services and the communities they work with.

Conclusion

This study has explored the complex dynamics between child psychotherapists working together as therapists and parent worker dyads within CAMHS, examining how trauma and racial differences shape this relationship when working with racially marginalised families Using IPA, the research has provided insight into the lived experiences of trainees and qualified child psychotherapists, highlighting the challenges they face when working with families specifically experiencing racial trauma. The study also considered participants' experience of working within a psychoanalytic framework that, at times, felt restrictive in addressing the real-world complexities they encountered. This further highlights that therapies and mental health professionals are often experienced as hard to reach, rather than the communities themselves (Partisan, 2025).

The themes of this research are by no means new; and have been explored in previous child and adolescent psychotherapy research (Horner (2022); Jackson (2022; Komakech 2023), specifically thinking about the impact of race on therapist-client relationships, within psychoanalytic training and how it is explored in supervision. However, this particular research highlights a further under-researched area. One of the central findings and main question of this study is the significance of

the child psychotherapist-parent worker dynamic, particularly how power and authority are negotiated within these relationships – an area that has received little attention in the existing literature. The research shows that whilst therapists work closely together, the nature of their collaboration varied significantly based on their level of training, institutional structures, and the implicit hierarchies within their teams. Trainees expressed difficulty in asserting their voices in both their therapeutic work and their professional settings, which had implications for their ability to engage effectively with their cases. The study also found that this lack of authority was often mirrored in their clinical work, where they struggled to advocate for themselves and their cases within the wider network. This was even more prevalent where these experiences reflected transferential communications from the families themselves. These findings echo broader concerns about power dynamics in therapeutic settings and emphasise how understanding the therapist–parent worker relationship can illuminate the conditions under which effective therapeutic work with racially marginalised families can occur.

The research also underscores the pervasiveness of racial trauma in the experiences described by participants and how this trauma extended beyond the therapy room into wider institutional structures they had to navigate. Participants described the ways in which schools, social services, and other institutions perpetuated experiences of racism and discrimination, which in turn influenced the therapeutic work and dynamic. Some therapists, particularly those from racially marginalised backgrounds themselves, expressed a deep personal connection to these experiences, sometimes to the point where it became overwhelming. The study also suggests that therapists from racially marginalised backgrounds may experience additional layers of emotional labour when working with families who have similar lived experiences, requiring careful consideration in training and supervision spaces and a reflective approach to working as a therapist/parent worker dyad. This directly addresses the research question by showing how the interplay of race, trauma and professional dynamics shapes both the participant’s experience of the dyad and the wider systems within which they work.

The findings suggested that trainees who felt able to openly discuss their concerns and countertransference with their supervisors or co-therapists were better able to manage the demands of their cases, highlighting the need for a more nuanced approach to case discussions and supervision that accounts for both the conscious and unconscious dynamics at play. However, the data also highlighted instances where the hierarchical nature of supervision or the therapist-parent worker relationship made it difficult for trainees to voice their struggles, leading to feelings of isolation and self-doubt. This reinforces the importance of fostering supervision spaces that encourage open dialogue, reflection, and support, conditions that are critical for participants working with racially marginalised families whose experiences of trauma are often complex and multi-layered. Future research could benefit from larger, more diverse samples, as well as alternative methodologies that include direct observation, focus groups, or work discussion seminars centred on the child psychotherapist and parent worker relationship.

Furthermore, the study highlights the ways in which racial, class and gender differences shaped participants' experience of their therapeutic encounters, their relationships with families and their navigation of wider networks. Whilst some therapists reported a deep sense of connection with their patients due to shared backgrounds and characteristics, others described discomfort, avoidance, or feelings of guilt when faced with similarities and differences. The data also suggest that these dynamics were often left unspoken, with therapists struggling to find ways to address race explicitly within their clinical work. This highlights the need for greater support around racial difference in psychoanalytic practice, as well as a more reflexive approach to understanding how these dynamics unfold in therapeutic relationships, underscoring how the therapist-parent worker dynamic can illuminate both the challenges and the possibilities inherent in therapeutic work with trauma in racially marginalised families.

Participants repeatedly expressed frustration at the limitations of the framework, particularly when working with families experiencing severe social and economic

deprivation. The study suggests that whilst psychoanalytic theory provides valuable tools for understanding unconscious processes, there is a need for greater flexibility and adaptation in how these theories are applied in practice. Recognising the significance of trauma, especially racial trauma, within these encounters appears crucial to developing such adaptations. Throughout this research, the theme of race emerged repeatedly as something capable of overwhelming the therapeutic work itself. Many of the participant quotes reflected this sense of being overwhelmed; by the scale of racial trauma, the depth of unconscious processes, and the networks surrounding families. This feeling became a thread running through the study: although the researcher was focused on the therapist-parent worker dyad, they remained aware that the broader issues of racism and trauma could easily overshadow the central research question.

In many ways, what one could say about racism and trauma could constitute an entire literature review in its own right, and yet the research question deliberately narrowed the focus to the therapeutic dyad as a way of making sense of something that remains in flux. By examining the dynamics between the therapists and parent workers, this study sought to understand how work with racially marginalised families and experience of trauma is experienced, mediated and sometimes intensified within this specific professional relationship. The research question was framed in this way because these are live and urgent issues with which the profession still struggles to engage and approaching them through the psychoanalytic lens in which the researcher has been trained offered a way of exploring them without losing sight of the people actually in the room doing the work. Given that psychoanalytic practice is centrally concerned with unconscious dynamics, it is impossible to ignore how these same processes shape professional roles, supervision, and the capacity to work effectively with racially marginalised families. On a personal level, this also raises the challenge of how to remain engaged without becoming overwhelmed. Framing the study in this way has been an ongoing attempt to keep returning to the research question.

Finally, this research contributes to the growing body of literature on the intersection of race, trauma, and psychotherapy. It underscores that, to understand what the therapist and parent worker dynamic can tell us about therapeutic work with racially marginalised families, we must not only examine collaboration, power, and authority but also place the participant's experience of trauma at the centre of our analysis. Reflexive thinking amongst child psychotherapists is essential to this process. In June 2025, the findings of this research were presented at the Society for Psychotherapy Research (SPR) 56th International Conference in Krakow. The feedback from this presentation highlighted important considerations for the wider profession, such as the need to explore themes of race and transference in psychotherapy training and supervision. Recognising and containing the sense of being overwhelmed, both within the therapist–parent worker dyad and within ourselves as practitioners, emerges as a critical step toward building therapeutic relationships that can meaningfully support racially marginalised families. This recognition could be a key part of re-evaluating traditional psychoanalytic training to better equip therapists to work with diverse populations and to make the therapist–parent worker dynamic a more effective vehicle for therapeutic change.

Acknowledgments

I would like to offer my sincerest thanks to my research supervisor Dr Rachel Abedi, who approached this research with as much enthusiasm, curiosity and vigour as myself. For not shying away from the difficult conversations and encouraging me to further my thinking.

To all of the participants, through which this research would not have been possible, thank you for sharing such vulnerable and moving accounts of your work.

To Becky Hall and the Stuart Hall Foundation, there is eternal gratitude for supporting my very first steps onto to this wonderfully complex doctoral training.

To Sarina N Campbell, Khuzuma Akhtar and Francesca Benjamin for supporting and championing me over the course of my training. Thank you for getting me through.

To my friends and family for offering the space and time for me to work on this research.

Lastly, I want to offer my thanks and appreciation to Kojo Apeagyei, for being a consistent sounding board and grounding figure during this whole process of thinking, writing and rewriting.

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Appendices

Appendix 1: Literature Search Process

Search Terms	Databases Searched
First search: (parent work* OR parent meetings) AND (child psychotherapy OR transference) (AB) AND (intergenerational trauma) **Second search:** (co-therapists OR therapist relationship) AND (countertransference)	APA PsychInfo APA PsychArticles PEP Archive PubMed Medline Psychology and Behaviour Sciences Collection SocIndex with Full Text

Inclusion Criteria
Peer–reviewed literature
Papers written/ translated to English
Linked full text available
Papers with child psychotherapy in the abstract
Papers within the last 30 years

With added limiters ‘academic papers’ and ‘full text available’ the first search returned 339 results; these were then individually explored by the lead researcher to assess for suitability against the inclusion criteria. This search yielded limited papers,

the most fruitful was found using the doctoral training’s reading lists, physical books and using the snowballing technique.

Appendix 2: Trust Ethical Approval confirmation

The Tavistock and Portman NHS
NHS Foundation Trust

Quality Assurance & Enhancement
Directorate of Education & Training
Tavistock Centre
120 Belsize Lane
London
NW3 5BA

Tel: 020 8938 2699

https://tavistockandportman.nhs.uk/

Kairo Maynard

By Email

11 October 2023

Dear Kairo,

Re: Trust Research Ethics Application

Title: *'What can the therapist – parent worker dynamic tell us about therapeutic work with non-white families? Is the patients experience of trauma significant in this?'*

Thank you for submitting your updated Research Ethics documentation. I am pleased to inform you that subject to formal ratification by the Trust Research Ethics Committee your application has been approved. This means you can proceed with your research.

Please be advised that any changes to the project design including changes to methodology/data collection etc, must be referred to TREC as failure to do so, may result in a report of academic and/or research misconduct.

If you have any further questions or require any clarification do not hesitate to contact me.

I am copying this communication to your supervisor.

May I take this opportunity of wishing you every success with your research.

Yours sincerely,

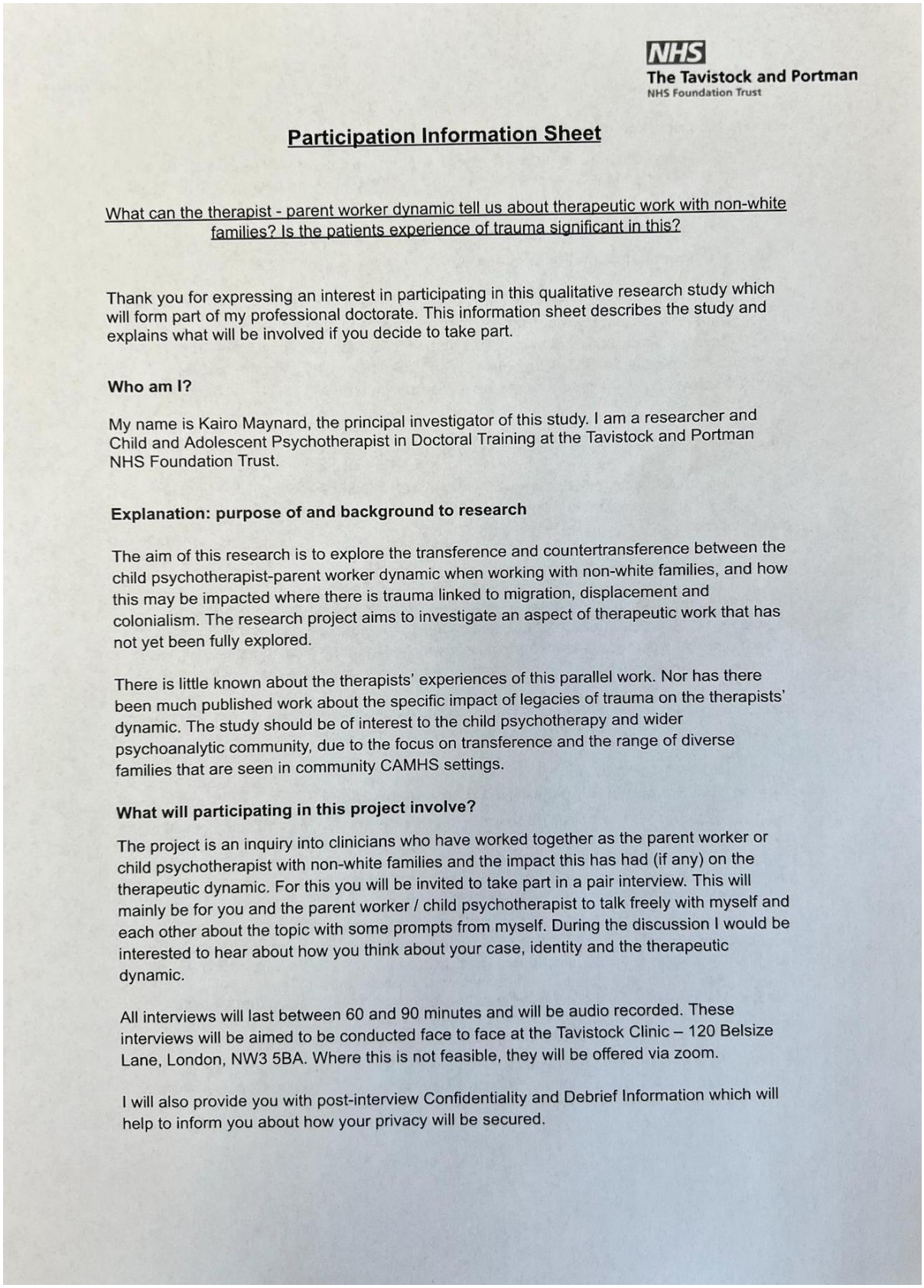
Michael Franklyn

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cc. Course Lead, Supervisor, Research Lead

Appendix 3: Public Facing Documents

Participation Information Sheet



NHS
The Tavistock and Portman
NHS Foundation Trust

Participation Information Sheet

What can the therapist - parent worker dynamic tell us about therapeutic work with non-white families? Is the patients experience of trauma significant in this?

Thank you for expressing an interest in participating in this qualitative research study which will form part of my professional doctorate. This information sheet describes the study and explains what will be involved if you decide to take part.

Who am I?

My name is Kairo Maynard, the principal investigator of this study. I am a researcher and Child and Adolescent Psychotherapist in Doctoral Training at the Tavistock and Portman NHS Foundation Trust.

Explanation: purpose of and background to research

The aim of this research is to explore the transference and countertransference between the child psychotherapist-parent worker dynamic when working with non-white families, and how this may be impacted where there is trauma linked to migration, displacement and colonialism. The research project aims to investigate an aspect of therapeutic work that has not yet been fully explored.

There is little known about the therapists' experiences of this parallel work. Nor has there been much published work about the specific impact of legacies of trauma on the therapists' dynamic. The study should be of interest to the child psychotherapy and wider psychoanalytic community, due to the focus on transference and the range of diverse families that are seen in community CAMHS settings.

What will participating in this project involve?

The project is an inquiry into clinicians who have worked together as the parent worker or child psychotherapist with non-white families and the impact this has had (if any) on the therapeutic dynamic. For this you will be invited to take part in a pair interview. This will mainly be for you and the parent worker / child psychotherapist to talk freely with myself and each other about the topic with some prompts from myself. During the discussion I would be interested to hear about how you think about your case, identity and the therapeutic dynamic.

All interviews will last between 60 and 90 minutes and will be audio recorded. These interviews will be aimed to be conducted face to face at the Tavistock Clinic – 120 Belsize Lane, London, NW3 5BA. Where this is not feasible, they will be offered via zoom.

I will also provide you with post-interview Confidentiality and Debrief Information which will help to inform you about how your privacy will be secured.

FIGURE 1 PARTICIPATION INFORMATION SHEET

NHS
The Tavistock and Portman
NHS Foundation Trust

What is the criteria to take part?

- Participants will need to be working with another child psychotherapist (trainee or qualified) offering weekly child psychotherapy and consistent parent work sessions with non-white families.
- Participants will need to be English speaking.

What are the possible benefits of taking part?

Although there are no formal benefits, I am hoping that having the opportunity to reflect and explore transferential and counter-transferential feelings within the therapeutic dynamic will offer some insight into your work the families that are receiving child psychotherapy. You will also be contributing to the knowledge base of the discipline of Child and Adolescent Psychotherapy, and to the broader network of the helping professions.

What will happen with the results of the study?

The documented results of the study will form my doctoral thesis and may also form an academic paper and feature in relevant published academic articles, books and/or presentations.

Do I have to participate after I agree?

No: participation in the study is entirely voluntary. Although your contribution would be invaluable, if you agree to take part but then change your mind, you can decide to withdraw and withdraw any unprocessed data previously supplied from the study up to two weeks after the initial interview has taken place without needing to give me a reason.

You are also welcome to think through the implications of your participation with my research supervisor, Rachel Abedi whose contact details are listed below.

General Data Protection Regulation (2018) arrangements

The Tavistock and Portman NHS Foundation Trust is the sponsor for this study based in the United Kingdom. I will be using information from you in order to undertake this study and will act as the data controller for this study. This means that I am responsible for looking after your information and using it properly. I will keep identifiable information about you from this study for 2 years after the study has finished.

Your rights to access, change or move your information are limited, as I need to manage your information in specific ways in order for the research to be reliable and accurate. To safeguard your rights, I will use the minimum personally identifiable information possible. I will use your name and the contact details you provide only to contact you about the research study. I am the only person who will have access to information that identifies you. I may be assisted in the analysis of this information by senior colleagues, but they will not be able to identify you and will not be able to find out your name or contact details.

You can find out more about the legal framework within which your information will be processed by contacting the sponsoring Trust's Clinical Governance and Quality Manager, Irene Henderson: IHenderson@tavi-port.nhs.uk.

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In the very unlikely event that you say something during the interview that suggests you or someone else is at risk of harm, I would need to discuss this with you and potentially breach confidentiality.

What risks are there?

There are no direct risks, but in the event that reflecting deeply upon clinical experiences may bring up challenging thoughts and feelings, you will be provided with information for services and individuals who may be able to help you to think about your experience in the interview.

What approval has been gained to protect you, and information about you, in the research study?

This research study has received formal approval from the sponsor of the research, the Tavistock and Portman Trust Ethics Committee (TREC). These processes ensure I conduct the study within legal and ethical standards. If you have any concerns or queries regarding my conduct you may contact Simon Carrington, Head of Academic Governance and Quality Assurance, Tavistock and Portman NHS Foundation Trust (academicquality@tavi-port.nhs.uk).

Additional accountability is provided by the study sponsor for this project, Elisa Reyes-Simpson, Interim Deputy Director of Education and Training and Dean of Postgraduate Studies, Tavistock and Portman NHS Foundation Trust, 120 Belsize Lane, London NW3 5BA, (ereyes-simpson@tavi-port.ac.uk).

Contact Details

If you have any questions or would like to discuss possible participation further, you can contact:

Kairo Maynard
Principal Researcher
kmaynard@tavi-port.ac.uk.

Dr Rachel Abedi
Research Supervisor
RAbedi@tavi-port.nhs.uk

Elisa Reyes-Simpson
Interim Deputy Director of Education and Training and Dean of Postgraduate Studies
ereyes-simpson@tavi-port.ac.uk

Thank you for considering taking part in this study and taking the time to read this information. If you are willing to be interviewed for this research project, please complete the accompanying consent form.

Consent Form

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Consent form

Project title:

What can the therapist – parent worker dynamic tell us about therapeutic work with non-white families? Is the patients experience of trauma significant in this?

Please tick boxes and sign against the statements that apply to you:

I confirm that I have received, read and understood the participant information sheet for the research study carried out. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.	
I understand that my participation in this study is voluntary and that I am free to withdraw my consent for any or all of the above at any point during my participation in the study and up to the end of the interview stage.	
I confirm that I would like to take part in the audio recorded interview as described in the participant information sheet received.	
I understand that direct quotes from the audio recording may be used in this research study but will be made anonymous to the reader and held securely by the researcher.	
I understand that it is my responsibility to anonymise any examples referring to cases I choose to discuss during the interview.	
I understand that the results of this research will be published in the form of a Doctoral research thesis and that they may also be used in future academic presentations and publications.	
I understand that there are limitations to the level of confidentiality that can be guaranteed in this study and that confidentiality may be breached if there are any disclosures of imminent risk of harm to you or someone else.	
I understand that interviewing about personal matters involves some risk of emotional upset or discomfort, that I can stop the interview at any time and that I will be provided with the details of sources of support.	

Contact details:

Researcher: Kairo Maynard Email: kmaynard@tavi-port.nhs.uk

Supervisor: Dr Rachel Abedi Email: rabedi@tavi-port.nhs.uk

Participant's Name (Printed): _____

Participant's signature: _____ Date:_____

Thank you for agreeing to take part in this study. Your contribution is very much appreciated.

Debrief Information

NHS
The Tavistock and Portman
NHS Foundation Trust

Debrief Information

Project title: A qualitative study on the impact trauma in non-white families has on the child psychotherapist and parent worker dynamic.

Thank you for expressing an interest in participating in this qualitative research study which will form part of my professional doctorate. This debrief letter offers information on the next steps and signposting to services if applicable.

What will happen with my audio recording after the study?
The audio recordings will be destroyed once the analysis and transcribing of the research is complete.

What will happen with the results of the study?
The documented results of the study will form my doctoral thesis and may also form an academic paper and feature in relevant published academic articles, books and/or presentations.

Where should I go if I need support?

In the event that reflecting deeply upon clinical experiences has brought up challenging thoughts and feelings, you are encouraged to access support via your team managers/ supervisors or personal analysis for trainee child psychotherapists.

However, if you need further support please see the following:

- NCL Keeping Well Hub
- Care first: Employee Assistance Provider (EAP)
- Speak with a Mental Health First Aider
- Race Equality Network
- LGBTQ+ Equality Network
- Purple Circle

Contact Details:
If you have any questions or would like to discuss possible participation further, you can contact:

Kairo Maynard
Principal Researcher
kmaynard@tavi-port.ac.uk.

Dr Rachel Abedi
Research Supervisor
RAbedi@tavi-port.nhs.uk

Thank you for agreeing to take part in this study.

Your contribution is very much appreciated.

Appendix 4: Interview Questions

1. Can you describe the case you are working on together (child psychotherapy and parallel parent work. Feel free to include referral information, treatment plan, family history.) Including ethnicity information of the patient and parents/carers. If this is absent, has it been followed up?

2. How long have you been working together for?

3. What was the thinking behind setting the treatment up in this way (ie individual work plus parent work), including who is offering the parent work (CAPT? Other?) and how often.

4. How is the treatment going, including attendance, engagement etc.

5. Can you describe the network involvement and dynamics as you see it?

6. Has difference come up in the work at all, especially (but not only) around race/ethnicity. Has this been discussed between them or in supervision?

7. Have there been differences of opinion between you regarding the case so far? If so what and how are these thought about? If not, any reflections on this?

8. Has there been any joint review yet? Was the young person present? (Encourage both to speak so that the experience of both is represented. There might be a particular power dynamic present, which will be useful to reflect on.)

9. Have there been instances where you have had a response about the case that could be linked to unconscious dynamics? Such as a body response or feeling towards the child/ parent, therapist / parent worker.

10. How do you think the family's trauma shows up in your work?

Appendix 5: Sample of data analysis process

Experiential Statements by interview

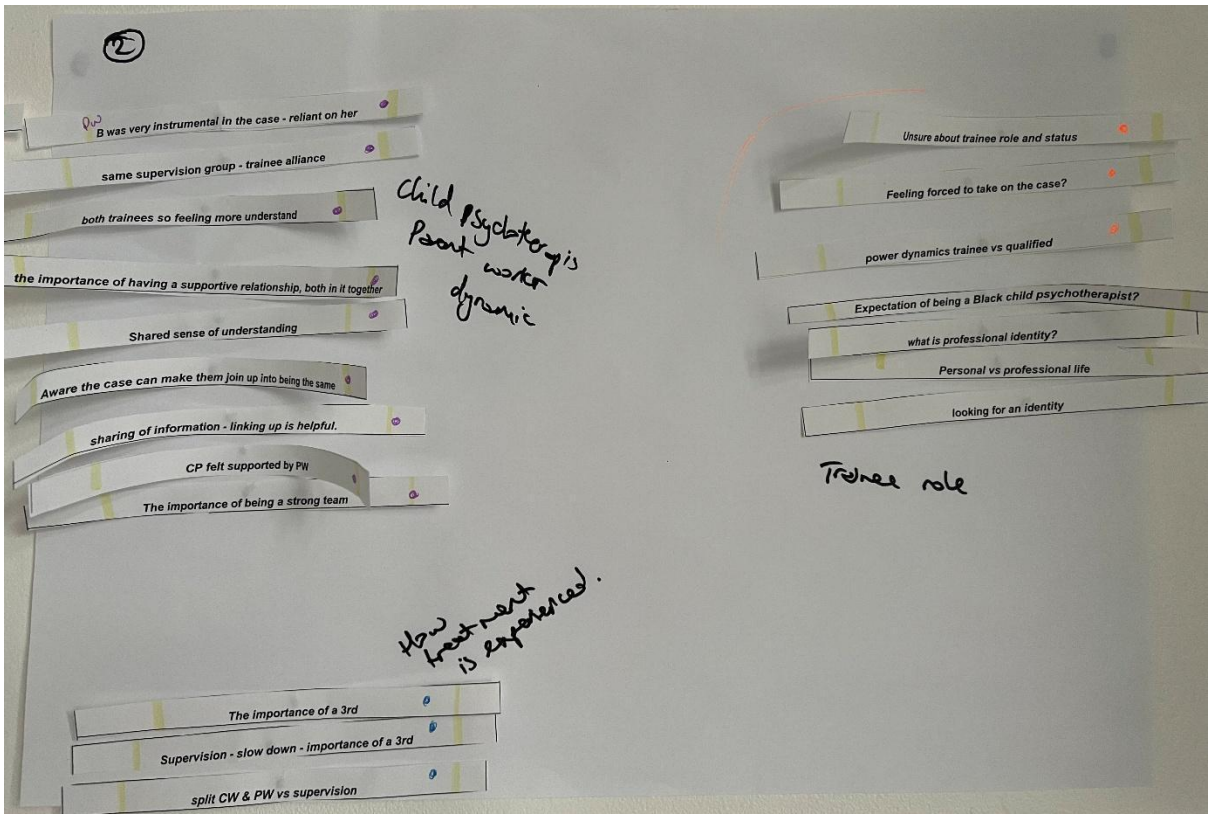
184	*acknowledgement they couldn't have worked alone on this, needed the support of e*	Interview 3
185	*PW aware of how the case made her act - pulled into action but grateful CP stayed s*	Interview 3
186	*the importance of a strong pair and team to offer holding and containment*	Interview 3
187	*there was something important about physically showing up to be with this family*	Interview 3
188	*confused, furious, distress and overwhelming feeling caused by racism*	Interview 3
189	*being in the service was a lifeline*	Interview 3
190	*acknowledging the importance of holding theory of trauma in mind but also recogni*	Interview 3
191	*trauma leaves feeling of violent, intrusive, unexpected, shocking*	Interview 3
192	*frightening of closing but hopeful there is a wider community the family are connected to nc*	Interview 3
193	*CP referring to PW for permission on information to share*	Interview 4
194	*unclear about mum's ethnicity*	Interview 4
195	*The trauma was a sudden event - taken by surprise*	Interview 4
196	*acknowledgment of the racial makeup of therapists to family*	Interview 4
197	*therapy offer was a lot for the family*	Interview 4
198	*a lot of information to cover*	Interview 4
199	*difficulties pre-bereavement around dysregulated behaviour*	Interview 4
200	*therapy done in school - easier for the family to manage and school were supportive*	Interview 4
201	*lots of worries about the boy, development and very dysregulated*	Interview 4
202	*recognition that Dad also needed to be seen regularly and children were seen intensive to a*	Interview 4
203	*impact of religion/ faith on the parent work*	Interview 4
87	*recalling family information is difficult - too much to hold onto*	Interview 2
88	*referral is about school related issues*	Interview 2

The researcher added all the experiential statements from the transcript to a spreadsheet.

Grouping of experiential statements by theme:

The researcher then colour coded and grouped the experiential statements into similar themes which formed the basis of the personal experiential themes. The process was conducted on paper in order to be fully immersed in the data.

Below is an excerpt of experiential statements from interview two, grouped into three personal experiential themes: *child psychotherapy and parent worker dynamic, how treatment is experienced* and *the trainee role.*



Appendix 6: Thematic Tables

Table of Personal Experiential Themes

Following this grouping, the researcher collated the themes into a table in order to better organise the PETs and improve readability.

Theme 1: the trauma was hard to be with	**Page/ Line**	**Quotes**
It's hard to be with the parent and the trauma	5/111	*it's just it's hard, it's almost like transference stuff. It's like, she's very like prickly*
Intense feelings of hopelessness and bleakness	12/360	*I felt so hopeless handing over from the parent worker, like what have I picked up, this is bleak..BLEAK.*
Anxiety can get into you	20/577	*We need to do this and there's this real sense of urgency. That really got into me and I promised all sorts,*
Theme 2: sameness/difference had a big impact	**Page/Line**	**Quotes**
Familiarity feels dangerous/ unboundaried?	24/730	*I need to calm down because there's such a familiarity. I feel like there's a familiarity between us*
personally seeing herself in mum vs professional life	25/750	*I think when I'm with her, that's probably more really where I'm from, right than when I'm in professional world, that's my background.*
Recognition of the damage that is done by assumptions/ stereotypes	37/1160	*It's not only that he's a quarter Black and the class, it's that his dad was in prison. Like, do you know what it does to people? The assumptions that people have once they, the school knows that*
Theme 3: Aware of being a trainee	**Page/Line**	**Quotes**
Power dynamics – trainee vs qualified	10/267	*but it didn't feel like maybe you were 100% on board when you when you're a first year trainee and someone says its time to close the case, youre like… OK.* *…. Yeah, and they're qualified*
Unsure about trainee role and status	11/311	*It did feel difficult. I remember feeling like, oh, I thought a qualified person had to take it*
Feeling forced to take the case	15/448	*And they were like, right. Psychotherapy case perfect for a trainee. Let's go*
Theme 4: CP and PW had a strong relationship		

Interview One:

Interview Four:

Theme 1: emotionally overwhelmed by trauma		
CP's experience of the case - floods of tears painful, feeling isolated at the school. Relieved by intensity of work	27/912	*I can remember coming back to the clinic and being in an absolute flood o tears, thinking this is, you know, feeling it's just so incredibly painful and frightening, actually.*
CW was overwhelmed - boy would scream - scared to challenge him.	29/967	*And he'd kind of hurl the tables through from there quite a lot. And it was loud, because he would scream. So there was quite a lot of physical. It felt quite a lot of stuff at the beginning,*
he was very likeable and the pain was palpable and overwhelming - school did not want to act	11/353	*I think it was palpable, really, that and people felt overwhelmed by the sadness about what had happened to him and how lovely he was.*
Theme 2: racial difference was hard to think about		
CW reflected on not picking up racial differences better - did not respond to boy trying to explore this	9/291	*I think our racial differences I would have picked up with much more confidence than I did, I tried to but, at the time. I think he was trying to to think about it and I didn't pick it up in in the way that I might have done.*
Different dynamics between the therapists - gender was a focus	19/603	*We we talked a bit about. I mean it. It was also that there's this, the obvious kind of racial difference. I felt very aware about being the only woman in the dynamic,*
PW felt it was important Dad could see a man - similarities offered space to work through emotions	26/870	*Yeah, I mean. In short, yes, I think, I think it it was important and I think it was important for him that he could see a man. I think that there was something very important for them about seeing a man trying to help them, to think about what they felt*
Theme 3: Being a trainee was difficult		
CW reflecting on this case being the first one, it was overwhelming, wished they had put in more boundaries/ were robust	9/286	*It was my first case. My first patient on the training, first intensive, plus the pandemic, plus everything else. I think a lot about how I would have done that differently. And actually, I think I felt very overwhelmed as, as indeed did he*

FIGURE 6 PET TABLE

Table of Group Experiential Themes

The researcher then cross-analysed and grouped the PETs further into three GET themes.

Table of Group Experiential Themes		
Theme 1: The impact of the trauma - somatic responses, racial trauma and mobilisation ad evacuation	**Page/ Line**	**Quotes**
Interview 1: the trauma was complex to be with	5/111	*it's just it's hard, it's almost like transference stuff. It's like, she's very like prickly*
	12/360	*I felt so hopeless handing over from the parent worker, like what have I picked up, this is bleak..BLEAK.*
	35/1091	*physically, it does make me feel warm. But then there's also sometimes I feel a bit scared that he might hurt me or that he's gonna throw something at me.*
Interview 2: Emotional response from trauma / hard to connect with family	6/204	*She was so overwhelmed. So, so overwhelmed. It was a lot. It's a lot of work. … But it felt endless*
	30/998	*I suddenly found myself being really, like, emotional and I was like… I'm left feeling really guilty*
	7/238	*Like I still feel very much like we're very far away. We're just getting to know each other, even though it's been quite a long time.*
Interview 3: the experience of trauma is violent / how do you meet needs?	3/87	*There's so much trauma that you like…And then every now and then you'd hear something really shocking.*
	2/37	*They both felt like they had the world on their shoulders a bit… But it also felt that she was quite depressed*
	28/922	*They felt really violent and and intrusive and unexpected and shocking…*
	21/663	*I remember when he was at home and we were doing it online. And I'll come for supervision and just talk about how like it feels like harmful to do that. It feels like cruel…*

Excerpt below of 'T*he impact of trauma*':

Excerpt below of '*How differences/ similarities are experienced and explored*':

Theme 2: How differences/ similarities are experienced and explored - the psychotherapy model and difference	**Page/Line**	**Quotes**
Interview 1: sameness/ difference had a big impact / Psychotherapy model felt restrictive with external deprivation	24/730	*I need to calm down because there's such a familiarity. I feel like there's a familiarity between us*
	25/750	*I think when I'm with her, that's probably more really where I'm from, right than when I'm in professional world, that's my background.*
	38/1182	Its such a split isn't it. It's like we've got this white, rigid, psychoanalytic professional who represents. "That's professional" you know? And then it's like these aspects of you that are so important, then they're not seen as professional…why
	40/1243	*I wanna think about it and what's happening" and it's like the response is kind of like I want you to feel freer to not have to know and not have to think about this too much…*
Interview 2: closeness / distance - related to relationship with the family and psychotherapy model	14/482	*Being a black person as well, perhaps, may have allowed them to speak more explicitly to those things.*
	27/910	*Or if there's something about like being really scared of the authority…*
	34/1139	*I think taking up the position as a child psychotherapist does sometimes feel like neglecting the external sort of realities…*
	7/238	*Like I still feel very much like we're very far away. We're just getting to know each other, even though it's been quite a long time.*
Interview 3: racial differences was a factor of the case / felt heightened by psychoanalytic model	10/329	*it felt like there was an identification with his being a black boy and us feeling horrified by what we were seeing and feeling a kind of a responsibility…*
	18/598	*I I mostly thought that in terms of my maleness. But I don't know if it is about the therapy role being different or about ethnicity.*
	16/520	

FIGURE 7 GET TABLE